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GUY'S HOSPITAL GAZETTE

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PASSIM

"I'M dreaming of a white Christmas," groaned the crooner and, characteristically, it rained. The bleak, grey sky, the wet mud, and the unadorned trees made a picture more like a real English Yuletide than any of the *olde tyme* scenes depicted on our Christmas cards. However, the unattractive coldness did not, it is hoped, pervade our inner selves and the warmth and plenty were enjoyed as always, officially or unofficially.

Now, with the last ward party over and only the hollow, funereal note of empty barrels in the hostel to show the end of the last carousal, we leave our cups and take up our books and instruments once more. Breakfast has again become a proper meal and not a hurried gulping of black coffee, with or without veganin. Fortified by our few extra calories we face the new year.

Our diaries will be kept up to the usual date, namely about the middle of January, and then will become as ever mere scribbling blocks for telephone numbers and addresses. The Wills Library will again be filled with bowed heads studying to the haunting tunes of a phantom wireless-set concealed, one knows not exactly where, high in the roof of a neighbouring building. Again will be heard everywhere the steady hammering of pipes and the dropping of zinc baths as the Works Department continues the reconstruction of Guy's. Bigger and better clouds of dust will be hurled down from the scaffolding outside Hunt's House, and who knows but the thud of falling timber may once more resound in the park where excavations to discover some lost city seem to be under way.

What of our New Year resolutions? Will we behave ourselves any better and any more wisely in nineteen-forty-seven than we did during the past year? Are we all resolved to appear as pleased to see our seventeenth peptic ulcer patient (in one morning) as we were to see the first and are we all determined to win gold medals?

We must, however, beware of the resolution to make ourselves *useful* at all times. Too many pairs of Spencer Wells forceps thrust into the surgeon's hand can be almost as disastrous as a scrum of zealous dressers pushing on eagerly to lift the patient off the operating-table. Fortunately new year resolutions, if made and maintained, are generally modest enough to pass unnoticed.

Guy's has seen many new years and gradually the rôle of famous names associated with its work has lengthened to make it one of the best known hospitals in the world. No matter how we may grumble about various features of its constitution and wonder what this ethereal "Guy's tradition" may be, it exerts an undeniable magnetic influence on all those who have ever worked within its walls. Old Guy's men so often admit that, on arriving in London after even a short absence, almost without realising it, they find themselves at London Bridge and once again walking through the colonnade.

The past year has shown the reappearance of many familiar faces on the staff and the restoration of the old surgical wards and operating theatres. Innovations have included the establishment of the Departments of Surgery and Obstetrics. Doubtless the coming year will have its noteworthy events. The old Spit will, it is hoped, soon be reopened and a new students' hostel is being set up.

Readers will be interested to learn that changes in the *Gazette* will take place shortly. The larger print will be noticeable and the small lettering in which Sports' Notices and Hospital Information have appeared will be abandoned in favour of larger type. Several requests have been received for the return to the original size pages of the *Gazette*, but paper shortage, at the moment, makes this step impossible, as our first objective must be to produce enough issues to make copies available to everyone.

VERY regretfully we say goodbye to Mr. Raymond Hinde who has resigned the Editorial chair. During his unfortunately short stay on the *Gazette* staff his many original ideas have brightened considerably our pages and we take this opportunity of thanking him sincerely for all he has done and of wishing him every good fortune for the future. We extend a hearty welcome to our new Assistant Editor, Mr. H. A. Ripman who, after a distinguished military career as a medical officer attached to the Irish Guards, has recently returned to Guy's to fill the post of obstetric registrar.

THE following extract from one of the leading women's magazines has been forwarded to us and will serve as a shrewd clinical observation as well as a warning to the Out-patient Department :—

> " There are certain types of skin on which lipstick always turns blue in winter. This is usually due to an acid condition in the blood, which can be rectified by injections of liver extract given by the doctor. Sufferers should be particularly careful to select warm, bright red shades."

WE are all proud to see the name of Miss Emily P. MacManus in the New Year's Honours List and, on behalf of all our readers, offer her our sincere congratulations.

A Case of Belladonna Poisoning

Presented by G. H. WARRICK.

(With the kind permission of Dr. Ellis.)

WALTER G., aged eight years, was admitted to Diplock Ward under Dr. Ellis, on September 30th, 1946, his father having noticed that he had staring eyes, a dry mouth, and " appeared to be seeing things which weren't there."

History of present illness.—On the day before admission, the boy was left to amuse himself in Guy's Park while his parents visited a patient in the wards. On arriving home his father asked him why his hands were stained and was told that he had been eating blackberries. The father then went back and identified the berries, and although ignorant of their potential lethal effect, administered a dose of castor oil to his son as a safety measure.

The child slept fairly well that night, but the following morning he was found to have staring eyes and a dry mouth, and exhibited signs of excitement in which he " saw things which weren't there and talked to imaginary people." He was then brought up to Guy's.

On Examination, 2.30 *p.m.*—The boy showed a flushed, dry skin, and a dry mouth. The pupils were widely dilated and gave an almost imperceptible reaction to light. He was restless and excited, and talked about imaginary objects.

Pulse, 100, moderate volume and tension.

Temperature and respirations were normal.

Cardiovascular and respiratory systems, no abnormal signs found.

Abdomen, possibly some slight tenderness in the right iliac fossa, but no rigidity was found.

The Jerks were brisk.

Kernig's Sign was negative, and there was no neck rigidity.

Rectal examination showed no internal tenderness.

Treatment.—Gastric lavage was carried out, and three or four remaining pips were washed out from the stomach. He was also given a colonic wash-out. Plenty of fluids were ordered, and a half-hour pulse chart was instituted.

Progress.—His condition remained unchanged during that afternoon and evening, and at night he passed into a state of rather restless sleep. Later he became quieter, and on waking at four o'clock in the morning he talked quite rationally.

During the early hours of the morning he was encouraged to sip fluids, but notwithstanding the dry condition of his mouth he needed persuasion. During this time his temperature and pulse rate rose, reaching a peak of 99.6 and 120 respectively at 2 a.m.

On Examination, October 1st, 10.15 *a.m.*—The pupils were still widely dilated, with no increase in the reaction to light.

The skin and mouth were dry.

His mental condition was now much improved, and he was quiet and subdued, answering simple questions.

Progress.—During that day his condition steadily improved, with the pulse rate and temperature falling to normal.

He ate a good dinner.

October 2nd.—He was now active and normal, and his speech was clear and intelligible.

The pupils were less dilated, and gave a clear reaction to light.

He was discharged and sent home.

Discussion.—The plants from which the berries were picked have been identified as those of the Atropa Belladonna growing near the Nurses' Home.

Many cases of poisoning by belladonna or one of its alkaloids have been described, and in Thompson's London Dispensatory of 1830 one reads that —" Children and the ignorant have often suffered from eating the berries, the beautiful appearance and sweet taste of which render them very alluring. The symptoms which they induce are those of intoxication, accompanied by

fits of laughter and violent gestures; great thirst, difficulty of deglutition, nausea, dilatation of the pupils, with the eye-lids drawn down; redness and tremefaction of the face, stupor or delirium, a low and feeble pulse, paralysis of the intestines, convulsions, and death."

In this case of belladonna poisoning this large assortment of clinical features cannot be claimed, but it did indeed give a very typical picture with the delirium, dry mouth and skin, and the dilated pupils.

It showed the unwillingness to drink, because although thirsty, deglutition was painful.

Most markedly of all it demonstrated the peculiar psychotic state of hallucinations, mania, and disturbance of speech.

The rise of temperature and pulse rate was not very significant, and it did not demonstrate the Scarlatiniform rash that may result from belladonna poisoning.

It was not ascertained how many berries the child ate as he wouldn't be more definite than describing the quantity as "a few."

A case has been described of a boy of fourteen years of age eating as many as thirty berries and surviving.

An interesting and rare case of belladonna poisoning was reported in the *Lancet* of 1921, when a man, his wife, and also their dog and cat, all showed dilated pupils and toxic symptoms after sharing a rabbit which had been snared in country where Atropa Belladonna was growing.

Treatment.—This is purely symptomatic. Gastric lavage and colonic wash-outs may be useful when instituted soon after the taking of belladonna by mouth.

Sedatives are of use in the stage of excitement, and morphia, chloroform, and ether have been given. Morphia, when given in some reported cases of belladonna poisoning, has been of value, but in the case in question it was considered that the crisis had already been passed.

Plenty of fluids should be given because of the decreased secretions.

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The Spirit of the Family Doctor

By HUGH BARBER, M.D., F.R.C.P.

Consulting Physician, Derbyshire Royal Infirmary.

So it is that he brings air and cheer into the sickroom, and often enough; though not so often as he wishes, brings healing.—R. L. Stevenson.

LET me begin with a reminiscence of a fairly recent date. We were a Study Circle of the British Medical Association, officially elected to discuss the re-organization of the medical profession under a National Medical Service. We did not all think alike; how could we? Better perhaps that we should not; but we had laid down the general principle that we would consider the best interests of the community.

We were studying the position and duties of the doctor primarily responsible for looking after the worker and his dependents. I do not like the appellation General Practitioner; it suggests a Jack-of-all-trades. I prefer the name of Family Doctor, for a man who can be, and frequently is, master of us all. I was taking exception to a scheme in which the family doctor would no longer attend confinements, because I believe his influence in the family would diminish. Of course, in these days of domestic problems, he is already doing less obstetrics as more women go into institutions for the event.

One of the surgeons of the Study Circle said that my view was all sentiment; the work could be done better by someone else. Of course it is all sentiment; that is just the point. When a woman has her first baby there is a lot more to it than just a child being born. The doctor who sees her through the confinement receives an affectionate regard, which lasts a long time, whether the mother is the wife of an artisan or what is called a great lady. He gains her confidence, which means so much to both and is of considerable importance for the future health of herself and her child.

Sentiment may seem to be so trivial. We do not wish to talk about it; we almost feel we ought to be ashamed to mention it, and only a gifted writer can express it in words; but if it be the right kind of sentiment it is one of the biggest things in life.

I can understand that when a young man sees a consulting surgeon, gives the name of his doctor and proudly claims that the old man "brought him into the world," it must seem rediculous to a materialist—quite likely, scientifically, the young man was no better than a B.B.A. But if you have imagination, it tells you that some mother has taught her son to respect the man upon whom she has relied in rough times and smooth. In these up-to-date days of mass psychology and propaganda I will not crack up sentiment for its own sake—I could not do justice to so great a theme. One might wander off into suggesting that social security may kill high adventure. Security may tempt us to invent our own anxieties, just as Alice in Wonderland said to her governess, "Let's pretend that I am a hungry hyena and you are a bone." What life may be like in the future nobody knows, but human nature will be much the same; and I am convinced that the confidence and esteem which the doctor receives from women whom he has attended in confinements is a very potent therapeutic agent, both in prevention and cure of disease, for herself and her whole family.

Suppose we take a simple story, which may be attributed to a friend of mine. He attended the wife of a curate in her first confinement, and in her own house. The monthly nurse was provided by the patient's parents. It all went according to plan, with "the gift of a daughter." A few months later the doctor came to vaccinate the child; only to be told by the mother that she would run into another room, because she was so nervous. I do not wish to be told she was rather a silly woman; it is part of the point at issue. The doctor told her to sit down and take the child on her knee. He said there were no nervous mothers in his practice—it was not allowed. As he prepared the child's arm (we did not do the leg in those days) he foretold the day when he and the mother would be in harness together over an obstinate tooth that was reluctant to sprout through the gum, or a day more distant when like all well brought-up children she would have spots like a leopard, because she had the measles—trivial stuff but sufficient for the occasion; and before the mother knew it, the vaccination was over. Rather like the story which the medical students related to Mr. Pickwick, of how Mr. Slasher had removed a boy's leg out of its socket so expeditiously, that "exactly two minutes after it was all over, tne boy said he wouldn't lie there to be made game of, and he'd tell his mother if they did not begin."

Some of my medical friends would say this is trivial and others that it is art. There are, of course, many ways of letting a woman know that she is the doctor's chief stand-by, and he is hers, in piloting her child through the early years of life. But it is a lesson she must learn, and doctor, mother and child will need courage and wisdom for the journey.

Now when we heard so much about cyclic vomiting and feeding children with glucose, this same doctor was puzzled to think that he had seen no such cases in his practice, until he realised that the disease does not exist where mothers are not allowed to be nervous. The pediatrist, with his trained hospital sister, will handle a nervous child with exceptional skill. On return to my old medical school I have been more impressed with a clinical round in the Children's Ward than with almost any other of the innovations—in my time they were nobody's children; just dotted about the adult wards in an odd cot here and there. The pediatrition knows that the treat-

ment of the nervous child begins with the education of the mother, but it is the family doctor who has the opportunity, and the specialist on some occasions must begin by removing the child from home surroundings, which should never have developed; and perhaps would not have done, if mother and doctor had begun with the right respect and good will engendered at the time of the child's birth.

In an idle moment, the day after I wrote these notes, I glanced at a newspaper, in which I read the words: "It is the decline of this great spiritual influence of motherhood among our people that concerns me far more than the falling birth-rate." Sentiment again, but I believe it is a sound one. If a change in the medical services is already taking away midwifery from the family doctor and eventually leaves him none, I believe that he and his patients will lose something which it will be difficult to replace. He can no longer be called the family doctor if the sentiment is gone. There may be some other way of keeping alive this feeling, but if we cut out the sentiment the doctor's calling may tend to resemble that of a mechanic dealing with machines.

It is no easy task to describe the best spirit of family practice as seen during the life of a generation. When a young man begins he is like a fish out of water. Even if he has acted as a locum on a few occasions, his new responsibilities are not the same. No matter with what senior he may be associated, he will feel lonely. You cannot mix the generations. It is all so different from working in a medical school or some resident post. If he comes across a nice presystolic bruit, he wishes to share the adventure with a colleague; or perhaps he spots an early disseminated sclerosis and is surprised to find that, it might have been better management to have allowed the diagnosis to come along, as it might be, more gradually and by stages.

I should say that for about five years there is some spirit of dissatisfaction. But all the time that he feels he has been doing rather trivial things, from the point of view of medical science, the background has been growing and contentment creeping in. A lot of things which he knew for examination purposes are forgotten now; but quite humbly he is conscious of the fact that he has learned much of real value which many of his examiners never knew. He cannot give it a name and perhaps never will, but something important is growing. He looks through all these articles in the medical journals, of which so few are any help. He keeps a notebook for new treatments which can be tried in general practice, but finds few of them convincing. He attends medical meetings where cases are shown; he meets some nice fellows, while medical knowledge advances. Perhaps in fifteen or twenty years he takes the presidential chair, and when he gives his address, we find that while others have been pottering about with knowledge, he has pocketed all the wisdom and we really learn something.

Nowadays we are so obsessed with the word specialist that we hear sometimes that there should be a speciality of general practice. This probably comes from a justifiable desire for the recognition of the gifts and experience gained in practice; although we must select a better word than specialist. It would seem to me that the reputation of the family doctor stood higher before the National Insurance Act came in 1913, although often he is a better doctor to-day, quite apart from his advantages from the progress of medical science. In the nature of things he is at his best as an individualist and the collective bargaining which National Insurance has entailed may have been detrimental to his good name. It has led to misunderstanding. I remember meeting some nice Trade Union officials, who wanted some cheap doctoring. They were posing quite genuinely as good Samaritans; and I could only tell them that we represented the society for prevention of cruelty to animals, whose duty it was to see that no beast of burden was given an unfair load to carry. As individuals we have many opportunities of showing generosity. If we are compelled to go a mile with anyone, when we are in no mood to go at all, we do not stop short of going twain. The public take our generosity for granted, which is a well earned compliment; and then in some collective bargaining we are misunderstood. Nevertheless, the family doctor who has the right spirit, can always command the respect of a host of individuals. And this brings his reward.

Perhaps the reputation of the family medical adviser was at its highest about 1891 when Sir Luke Fildes painted his picture, "The Doctor." At that time, nearly all those with a medical qualification were engaged in clinical work. They knew the difficulties of the doctor's calling and they knew his worth. During my time I have noticed a tendency towards criticism of his work which has been unfair, although sometimes given inadvertently. When the Minister of Health states in the House of Commons, "That measles is now a preventable disease," it naturally creates the impression that the family doctor is out of date when he says, that children should

have the measles at home, to get it over, before they go to boarding-school or college. The public do not hear the other side of the story, when the minister's grandchildren and those of his chief medical adviser, have the measles in due course.

The clinician knows that some types of health propaganda make for disease consciousness. He believes that, often enough, it goes to the wrong address; so that a so-called Health Week leaves him rather cold. His want of interest may injure his reputation, or at least there may be the impression that, if the public could only have a doctor like the lecturer they would indeed be favoured. In my Out-Patient Department a mother brought me a boy, ten years of age, whose head had been turned by health lectures at school. He would come home and refuse to drink tea but ask for water. I invited him to write out some of these ideas and bring them to me. Amongst others I learned; "then the lecturer writes on the board how to avoid influenza." A few years later, when he takes his medical card to be signed by a doctor, he may be disappointed with some of the replies to questions he may put. The family doctor, in the main, grows into a man of outstanding merit, so that perhaps it does not matter. But I think it is true that both salaried specialists (in contrast to consultants) and the numerous people with a medical qualification, who do not practice clinically, have done something to injure the reputation of the family doctor.

Great changes are under discussion. Sir William Beveridge has written that it may not be worth while to keep private practice going. Should this be the case, the doctor primarily responsible for the individual—that is the new family doctor—should insist that he goes to the top, with the right to see that the public health services, the consultants, the specialists and the hospitals, provide what he requires for his patients.

Now about this wisdom which he gains. The individual wisdom of the family doctor is valued by many consultants who are associated with his work. They learn from him things which are outside their own experience. The part of an illness which they see, is made into the whole picture by what the doctor in charge can relate. But there is scope for Collective Clinical Wisdom, which is in evidence when experienced family doctors take part in some clinical discussion. There is an interesting record of a meeting of the London Medico-Chi. in 1888, when a discussion on puerperal fever was opened with a bacteriological paper giving evidence of streptococcal infection. Of the six speakers who followed, half favoured the "germ" theory, and half the autogenous (whatever that may have been). A country doctor, from Reading, spoke for the germ theory, giving his personal evidence that unhealthy dwellings were a fertile cause of the disease.

We all know of the famous men, Jenner, Koch and Mackenzie, who came from general practice. These names, or others, may be mentioned at a medical meeting in the spirit which suggests that a similar life might come to some of the members present; but the real compliment should be that when any new scheme for preventive or curative treatment is under discussion, there is need to seek the collective clinical wisdom of family doctors, which can be expressed in clinical meetings.

In more recent years one has heard the proposal that State Medicine should meet clinicians for discussions, from which both might profit. There has been little of practical value, however. Some time has been expended on the economic aspect of who should do some work—whether the family doctor or the whole-time officer. The work in many cases might have been better done—occasionally perhaps better left undone—if the wisdom of good family doctors had first been sought.

Professional rivalry is a very difficult problem. From this I have seen much stimulus for good and little which did harm. The un-ethical have had their short day and not prospered for long. Fancy treatments and self advertisement of the Bob Sawyer type soon cease to impress. But a little local rivalry judiciously worked up may be beneficial. I have known a village where two practices kept apart deliberately. The story goes, that the villagers would pick up sides on the bowling green, Dr. A. *versus* Dr. B., although neither doctor was present—as it might be married *versus* single or Liberals *versus* Conservatives. It was really a pose. Samuel Johnson once said that he liked a good hater, by which, I take it, he meant that a firm dislike of one thing implied a warm advocacy of another. I believe with these shrewd old enemies that it was a put up job. Then came junior partners who bridged the gulf by playing cards together. Hot partisanship could not stand up to this; things became lukewarm and eventually two practices fused together.

There is nonsense talked, in the abstract, about professional jealousy. It is a grievous fault to be envious of another man's success, but a doctor must be jealous of his reputation. It is one of his best therapeutic agents. We cannot lay down fixed ethical laws and it is better to think of the "Golden Rule"; although even the Royal and Ancient at St. Andrews would be hard put to it to interpret this rule in some cases.

Well, here is my suggestion. Never allow the other man's reputation to suffer through your action or word. I would fix this firmly in the minds of all reputable members of the medical profession. A doctor's reputation is one of his most important assets in treatment. No one of us knows when some desperate unavoidable catastrophe may come our way. We all live in glass houses, and happy the man who feels that his own reputation is so sure that he dare admit that some disaster, of which he may hear, might have befallen him. Dr. Guthrie tells us that, Isaac Judæus, an Egyptian Jew, in the ninth century A.D., put forth the maxim: "Should adversity befall a physician, open not thy mouth to condemn, for each hath his hour."

Sometimes the doctor needs saving from his friends. A woman patient may injure him with injudicious praise. Or on the other hand a faithful friend may be so full of gossip about her symptoms that the doctor's reputation may suffer. These things must not be taken seriously. History relates that a distinguished Manchester doctor, at a medical meeting, was told that some patient had said that she had been under his care for twenty years and that he had never done her any good whatever. He responded: "Twenty years; that is a long time. How many people are there in this room who can keep a patient twenty years, when they have never done her any good whatever?"

A reputation sometimes may be based, in part, on the attendance at some baronial hall. There is a record of William Battie, elected a Fellow of the Royal College of Physicians in 1738. When he was a young fellow he started practice in Uxbridge. He was much esteemed by the Provost of Eton, who sent his carriage with four horses to bring the doctor to him; but when the doctor prepared to prescribe, the Provost, who was ninety-four years of age, said, "You need not trouble yourself to write; I only sent for you to give you credit in the neighbourhood." That was a long time ago. Not many people remain, who feel themselves to be so important as that; but to attend at some country hall may bring prestige in the farms around, and if there is a change of doctor it cannot be hid. It must make for some element of rivalry, for which the best corrective is to fight it out on the golf course.

It is an old saying that it is easy to make a reputation but that it takes a good man to keep it. That should be the spirit for the family doctor. He should not be in a hurry to gain credit in the neighbourhood, but should build upon the sound foundation of good work, carried out according to his natural character.

He must be prepared to find that a difficult patient may leave him for a rival, and just to prove her case, will become easy to manage by the new doctor and loudly sing his praises—for the time being at least. He must remember that he will gain some reputation from happy events over which he had little or no control, and must be prepared to suffer for misfortunes for which he could not justly be blamed. Soon after I was in sole charge of a practice, an important elderly man had to be introduced to "catheter life." We did not remove the prostate in those days. He made satisfactory progress and was carrying on his business, but on the morning following one of my visits he died suddenly in his chair. Three married daughters were there on my arrival, all calling out to know why I had not told them that their father was going to die. They all changed their doctor; which from their point of view I could understand. For myself it seemed a bad beginning; but in case this should meet the eye of some doctor with a loss of reputation from similar event perhaps there is no harm in adding that, I have seen in consultation since, the husband of one of these ladies and the grandchild of another.

If one is taking a survey of family doctoring in my time, it is not without interest to note that a generation of rich people grew up—mostly out of the first World War—who were too self-important to have anything so ordinary as a family doctor. Some people may have heard of a book called the *Citadel*. Now if we were all scholars, as formerly, and this book had been written in Latin, it would have been a very good book. It exposed the malpraxis of a ring of so-called specialists. But written in our mother tongue it is open to the criticism that it made a sensational appeal to those who could not see all round the problem. I accept the last episode in the book as the author's idea of good medical practice, although I myself wish to see all special

branches of medicine practised from large hospitals. For the main theme of the book, however, should not the author have made it plain that, none of these rich people need have been exploited, if they had been wise enough to have a good family doctor ?

There is a history of medicine to be found in the pages of *Punch*. Most of the jokes are against the patient and the doctor's foibles receive sympathetic treatment. There is one bitter jest, however, of a distinguished surgeon, who when asked what a certain operation had been for, replied a hundred guineas ; and the question then corrected to what the patient had got, brought the same answer—a hundred guineas. This was in 1926, about the time when the rich were going direct to the specialist after the first World War. The picture was making history ; because it is the pride of our profession that a good family doctor can always get what is really distinguished assistance, when it is really needed, free of charge or at a minimum cost.

There can be no batsman without a bowler ; you cannot have a consultant without a family doctor and even if there is only one needed for a diagnosis (which as a consultant I am not prepared to admit) you must have two for the treatment. Here is a simple story. A friend of mine took a small boy up to London to see a distinguished orthopædic surgeon. There was a birth-palsy around the shoulder joint. Perhaps it is called Erb's paralysis. The surgeon gave a very clear opinion ; his whole technique was perfect. He then said he would like the child to sleep with his arm away from his side ; turning to the mother and suggesting she might put a pillow between the body and the arm. The doctor said they should buy the biggest Teddy Bear in Hamley's. The surgeon turned to his secretary and whispered, " Make a note of that." That is consultation. How could a family doctor of experience miss a thing like that ? When a man has stood by a mother, many times, at the side of a cot, he must sometimes have felt sentimental about that doll clutched to the side of the sleeping child. It is contrary to both sentiment and science to pull it out and replace it by a pillow. He did not know that it might be useful for Erb's paralysis, but the words sleep and child filled his mind with pictures. There must be two to a consultation.

Some fifty years ago there was a catch-phrase, " What shall we do with our girls ? " It would be easy to answer now, that we must keep pace with them if we can ; but time was when many of them became children's governesses. One of the biggest changes in family doctoring is the loss of these women and of the faithful maid. There was moreover some girl, who could take over family and home nursing duties in most of the streets where artisans dwelled. Some of my generation could tell a long and sentimental story of those happy, helpful women of the past, sowing kindness and reaping sympathy ; never in want of a home. Some of them helped to bring up three generations of children—they knew all child psychology and their example was merged in precept. What a lot a young family doctor learned from them. It was of the utmost importance to gain their confidence, and on the whole it was gained by quiet, efficient doctoring—such a woman was looking on, she had not chosen the doctor but could judge his worth.

Sometimes the young untried governess put up a cry for sympathy of an hysterical nature. Thirty-five years ago, at a dinner-party, a woman told me of her unfortunate experience. It seemed that a new governess had been a little overcome by some unruly children, which led to some sort of collapse. A phlegmatic husband advised my friend to burn some feathers under the patient's nose. This set up a convulsion, so that the husband had to carry her up to her room and run post-haste for the doctor. Here was further misfortune ; the doctor was on holiday and an unknown locum was in charge. Husband and locum came hurrying round together, and when the mistress of the house explained the serious situation to the doctor as he climbed the stairs, he sat down half-way and shed tears of silent laughter. This was the story I was told at the dinner table, and I was asked, " What sort of a doctor was that, to be left in charge of the practice ? " Well, I said then, and I still think, probably a good one. But I told my friend that she had every right to be cross with him.

The difference between the chosen consultant and the official specialist of State Medicine is worthy of consideration. In British medicine, of which we are justly proud, the consultant has relied economically upon the support of the family doctor. It has been an excellent stimulus. As a political catch-phrase this is called a profit-motive. But a wise patient knows. He understands the motive and whom it profits when the consultant and the family doctor meet.

It is probably that Stevenson's ill-health is the reason why he wrote so kindly of the medical profession. If the rich man or the politician is ill he develops a respect for the doctor in charge of his case; but it would seem, that in good health, he may be less sympathetic to our profession. Those who are in the habit of exercising power may find us elusive fellows.

The family doctor is at his best as an individualist. What a pity that those words from an Epistle, "to be all things to all men," have sometimes been misinterpreted as suggesting a character not quite honest; whereas their spirit is to have charity and understanding for every point of view. The family doctor in my time may claim to have been all things to all women and children. We may smile sometimes with *Mr. Punch* over bedside-manner jokes or other little ways, but there comes the day when the doctor arrives cool, collected and understanding when circumstances are grave, and we meet the man himself. Rarely do we find him wanting.

A few years ago, I was asked to visit a child four years of age, who was the grandchild of a doctor. It was obvious that she was nervous, but we carried off the situation without mishap, including a thorough examination. After which it was evident that she had found the new experience quite enjoyable. As a token of regard she handed me a picture she had drawn; and just as I left the bedside a small voice uttered the words: "I thought you'd be worse."

The child is the best teacher of psychology, and I think this remark sums up a great deal of the spirit of what a patient feels after the doctor's visit.

THE DOCTOR OF THEIR CHOICE.

"I like my doctor," said the Old Lady, "because he has such a restful bedside manner."

"We love our doctor," said the Children, "because he's such fun."

"I trust my doctor," said the Mother, "because he was so careful when the children were born."

"My doctor is a bit independent," said the Business Man, "he won't suit my convenience unless he thinks I am seriously ill."

"Nothing is too much trouble for my doctor," said the Poor Relation, "I can never repay him for his kindness."

"I can pay my doctor's bill," said the Octogenarian, "he is a cheerful fellow. I was just such another at his age."

"The doctor who calls at our house," said the Children's Nurse, "always has a smile and a word for me."

"Would it not be convenient," said the Stranger, "if all you people had the same doctor?"

"Of course," they all exclaimed; "so we do."

Correspondence

Passim

SIR,—Advancing years and the decay of the postero-lateral group of my hypothalamic nuclei cause me a wistful envy of the aggressive vitality shown by Mr. Stafford Clarke in his recent attacks upon you. I fear that your Passim of November 23rd, 1946, evoked from my nervous system only a gentle melancholy unproductive of combativeness.

I think you are right to be sceptical both of psychiatry and of psychiatrists. For, it is a field of work which has never consistently attracted the best brains of the profession. Its very nature often attracts the psychopathic themselves to its study. It has become "fashionable." There is a discernible tendency for its exponents to offer more than they have to sell. Psychiatrists discussing the brave new world often imply that they alone should hold Government Office. All this forms a reasonable ground for scepticism.

But the scepticism should itself be reasonable. After all, the position of psychiatry as a specialty has evolved from the inevitable failure of the general

physician to deal with its problems. And it is not entirely the fault of psychiatrists that much of the work has to be carried on under conditions remote from the general public, with the implication that it is also remote from reality. And while those now actively engaged in it may at times be over-enthusiastic, yet they are of the same order in the evolutionary scale as the rest of the medical profession, with a high degree of similarity in their powers and processes of reasoning. And the history of psychiatry has many illustrious names. It can hardly be expected, therefore, that all psychiatrists are fools.

Psychiatry at Guy's, since I have known it, has always been eyed a little bit askance and has occupied, in the hospital life, somewhat the position of the mother-in-law or the absent-minded professor on the music-hall stage. This has been partly through pressure of the ever increasing medical curriculum, partly through poor clinical co-ordination, partly through lack of in-patient accommodation, but mainly through lack of early teaching and through an inadequate appreciation of the size of the problem. The late Dr. R. D. Gillespie was keenly conscious of this and often discussed it with me. I always gave the same answer, and the passing of the years has confirmed me in my view. What is important is that there should be some orientation towards the subject; and that can be achieved only by the introduction, at an early stage of medical training, of a human approach to medicine. I do not think it unfair to say that when I was a student at Guy's we were always told that one must treat the patient and not the disease, but, with few noteworthy exceptions (an E.N.T. surgeon was one of them) no one ever did it. We treated diseases, not people. As a result we were less well equipped than for any other branch of medicine for that particular branch which above all others requires the human approach. We had no orientation towards it.

Your Passim of November 23rd, I think, shows this trend clearly. It is, sir, so very detached. Of course the so-called modern psychiatric treatments (some of which have been going on, on and off, for upwards of eighty years) are bizarre, crude and empirical. The remarkable thing is that they sometimes work and bring some degree of relief to such scourges as schizophrenia and manic-depressive psychosis which have for so long baffled the combined efforts not only of psychiatrists, but of geneticists, neuro-pathologists, biochemists, endocrinologists and general physicians. The possible contribution to knowledge arising out of these treatments must be recognised in any intelligent conspectus of the medical field as a whole; they form a challenge and an opportunity to all who study medicine.

But you, sir, seem to view them from a very great distance, and as worthy of notice only as a historian might make casual reference to some freakish eccentricity, as something lending colour to an otherwise monotonous life. I think it must be this which has stung Mr. Stafford Clarke. It does not sting me. But I think it a pity that at Guy's, where so much earnest toil by a great man has produced such facilities (facilities which, at any rate until recently, have been unrivalled by any of the other great teaching hospitals in London) for an understanding of this subject which is an inescapable part of medicine, there should still be such a degree of dissociation between these various fields of study as is shewn in your editorial. I doubt that such remarks could ever be made, for instance, in any hospital journal in the United States: not because of censorship, or impropriety or bad taste or anything of that sort, but simply because in that country they have an orientation towards the matter which would make remarks in such a vein impossible.

I am aware that at Guy's things are already much different from when I was a student, but there remains a great deal to be done. I beg, sir, although it may well be considered to be no longer any concern of mine, that you will not foster this dissociation further.

Yours, etc.,
MAURICE PARTRIDGE.

St. Andrew's Hospital,
Northampton.

The Out-Patient

SIR,—I sent a man to medical out-patients about his chest. The enclosed is a copy of the letter he wrote to the manager of his firm. It gives a picture of how the out-patient finds that department at Guy's.

Yours, etc.,
M. E. S. FOX.

3, Keetons Road
S.E.6.

24th November, 1946.

Dear Fred,

I received your letter, so here goes. First of all, I must thank Mr. Hider for the voucher. Well, Fred, they certainly went all out this time. First, everything off bar your skin, then on the scales, then a sample of your water (rather embarrassing for the nurse—she's there to see there is no fiddling, I suppose). Then wait your turn for the doctor. Well, Fred, there was the usual morse code all over the back and front with a series of " gg " now and again, then a blood pressure test, then you may dress. The nurse handed me two papers, one she told me to take along to the fourth door on the right. Well, along I go, it was labelled Plaster Room; I thought this is a new one on me, then in I go. The nurse read the paper and said " Strip," but I was allowed to keep my trousers on here; then she looked me over and apparently decided the only place I had any blood was my arms, so she started scrubbing them with some spirit, and then she pokes a syringe in and starts syphoning some blood. I thought if she takes much of that there's going to be some trouble. I suppose when they took the blood pressure test they thought I had too much, eh Fred? Well dress again, then to the X-ray Room. It was a scream here, Fred. I found it alright, the door was open so in I went. I went into both the X-ray Rooms and there wasn't a soul to be seen. I thought to myself they have all gone to dinner. I found a posh lounge with sofas and easy chairs with cushions, etc., so I decided to take a chair and wait. Well, presently along came a nurse—didn't she jump when she see me. Well, when she recovered she asked what I wanted and why hadn't I rung the bell. Apparently this was the nurses' sitting room that I was in. Well we got over that and she took me to the dressing room and of course said " Strip." Well off they came again. It was a kind of cell with a door one end where I had entered and the other end a curtain on a rod. Well, when I was ready in a dressing gown I had to peep out of this curtain and there was a chair outside a door in a sort of corridor. I went and sat on this so as I wouldn't be forgot. Well, after a time along came a nurse, she looked at me and then asked me what I wanted. When I told her she said I should go out the other door, as only mothers wait there for the doctor. Apparently this was the maternity doctor. Well,

Fred, they X-rayed me alright and I was allowed to dress and go. I am to go again on December 6th. I suppose in the meantime they will examine the bits and pieces and will then be ready to start operations. Well I think there is only two things left now, that is, either a blood transfusion or some monkey glands.

Well, Fred, apart from all this I am more satisfied now, in fact I feel better already; perhaps taking that drop out has made all the difference, eh Fred? I must thank both you and Mr. Smith for your great interest and for your efforts on my behalf. They have certainly set things moving. I will let you know Fred how I get on when I go again on December 6th. Until then, Cheerio to you all from

Yours sincerely,

F. S. (Signed).

Sport

BOXING

The Club has every reason to expect a successful season. There are about twenty active members, over half of whom boxed for the Hospital last year. Several of the newcomers are showing great promise and, with the experience of a few matches behind them, should prove formidable opponents in the University and Inter-Hospital contests.

Any new members would be welcome, especially in the lighter weights, as the Club is short of men under nine stone.

Training takes place in the gymnasium every Tuesday and Wednesday afternoon, under the direction of the Club's coach and trainer, Mr. Matt Wells.

Oxford University and St. Mary's Hospital Boxing Clubs are providing Guy's with two more fixtures this year before the Inter-Hospital Championships which will be taking place in March. Details of these fixtures will be announced later.

OXFORD AND CAMBRIDGE UNIVERSITIES *v.* UNITED HOSPITALS.

This match took place on November 26th and was held at Eltham Baths. Guy's provided five of the eight Hospital men and four of them won their contests.

Featherweights.—E. R. Lubbock (Oxford) lost (k.o.) to A. R. Tenton (St. Mary's).

Lightweight.—D. Bale (Cambridge) won on points against M. Mason (Guy's).

This was a close contest and Mason scored well with his powerful left hand, but his opponent was fitter and had the advantage of five years more experience.

Welterweight.—R. Brazier (Oxford) lost on points to W. M. Sheeran (Guy's).

Sheeran was right on top of his man in the first round and delivered some damaging body blows, but Brazier made a good recovery and forced Sheeran to box more carefully. However, the Guy's man was very quick and maintained his points lead.

C. Desaran (Oxford) won on points against I. W. Gregory (St. Thomas's).

D. Stephenson (Cambridge) won on points against A. Grantham (St. Thomas's).

Middleweight.—R. A. Powell (Cambridge) lost on points to A. E. McLauchlan (Guy's).

The scoring in this match was very close. Powell went down for a short count at the end of the first round and McLauchlan was put down for a similar period near the end of the last round. The Cambridge man did most of the attacking but McLaugclan forced him to keep his distance with straight lefts, although he should have made more use of his right hand.

J. Russell-Jones (Oxford) lost (k.o.) to R.D. Walsh (Guy's).

The Oxford man was strong but had a poor defence of which Walsh was quick to take advantage. By picking his punches the Guy's man soon had his opponent worried and with a well-timed right cross floored him half-way through the first round.

Heavyweight.—T. Fletcher (Cambridge) lost (k.o.) to B. Cole (Guy's).

The Cambridge man boxed back well at the beginning but Cole's strong, accurate punching put him down for the count in the first round.

Result : United Hospitals won, 5—3.

Hospital Information, etc.

NOTICES

SOCIAL MEDICINE

The following Lectures in Social Medicine will be given by Professor John A. Ryle, M.A., M.D., F.R.C.P., Professor of Social Medicine, University of Oxford, at 1.0 p.m. in the Physiology Theatre.

1947.

Tues., Jan. 7th. "The Meaning of Normal and the Measurement of Health."
Tues., Jan. 14th. "The Natural History of Tuberculosis."
Thurs., Jan. 23rd. "The Social Pathology of Rheumatic Fever."
Thurs., Jan. 30th. "Peptic Ulcer as a Social Problem."

DEPARTMENT OF SURGERY

A demonstration of partial thyroidectomy will be given on Tuesday, January 7th, at 12 mid-day, in the series illustrating standard surgical procedures.

Mr. Eckhoff will conduct a departmental round in Queen Ward on Saturday, January 11th. Cases illustrative of the principles of Plastic Surgery will be shown.

On and after Monday, January 13th, exhibitions of pathological specimens, X-ray photographs, microscopic slides, diagrams and cartoons will be held in the Gordon Museum. These exhibitions, each of which will be concerned with some phase of surgical disease, will be changed once a month.

H. J. B. ATKINS,
Director of the Surgical Department.

THIRTY CLUB

The first post-war dinner of the Thirty Club will be held at the Trocadero Restaurant on Friday, May 16th. Further details will be circulated later, but members are requested to send their present address and to indicate whether they propose to be present at the dinner as early as possible to the honorary secretaries, Mr. V. E. Lloyd or Sir John Conybeare, Keat's House, Guy's Hospital.

GUY'S HOSPITAL STUDENTS' PHYSICAL SOCIETY

President : Sir William Hale-White, K.B.E., M.D., F.R.C.P.
Secretaries : Patrick Clarkson, Esq., M.B.E., M.B., F.R.C.S.
Stephen Llewellyn Smith, Esq., B.M., M.R.C.P.

Thursday, 16th January, at 5 p.m., in the Physiology Theatre.—Sir Herbert Eason, C.B., C.M.G., M.S., F.R.C.S.
"*What a Doctor Must Not Do.*"
(Sir Herbert will include references to any possible changes produced by the new Health Act.)

Thursday, 30th January, at 8 p.m.—Clinical Meeting.

Thursday, 13th February, at 5 p.m. Professor J. McConn, M.R.C.V.S., M.R.C.S., L.R.C.P. Royal Veterinary College.
"*The Veterinary Surgeon and his Place in our Life.*"

Thursday, 27th February, at 8 p.m.—Clinical Meeting.

Thursday, 13th March, at 5 p.m.—Paper.

Thursday, 27th March, at 8 p.m.—Clinical Meeting.

Thursday, 10th April, at 5 p.m.—Professor W. E. Gye, F.R.S., M.B., Ch.B., M.D., F.R.C.P. Director of the Imperial Cancer Research Fund.
"*Problems of Cancer Research.*"

Thursday, 24th April, at 8 p.m.—Clinical Meeting.

Prizes.—The following prizes are awarded annually by the Physical Society :—

1. At the end of each Session a Prize to the value of £10 is awarded to the Member who is judged to have read the best paper before the Society.
2. The Beddard Prize, approximately £2 5s., is awarded to the member who distinguishes himself in the demonstration before the Society of a Clinical Case.
3. The Laidlaw Prize, approximately £2 10s., is awarded to the member who exhibits the specimen or reads a paper before the Society of the greatest Pathological Interest.
4. The Treasurer gives annually a Prize of £5 for the best essay on some set subject. The successful Essay is read at the last Meeting of the Session.

   The subject for the 1947 Prize Essay will be announced shortly.

PASS LIST

UNIVERSITY OF LONDON.
EXAMINATION FOR THE ACADEMIC POST-GRADUATE DIPLOMA IN MEDICAL RADIOLOGY.

November, 1946.

PART I.

P. M. Davies.

UNIVERSITY OF CAMBRIDGE.
FINAL M.B. EXAMINATION.

Michaelmas Term, 1946.

PART I.

Surgery, Midwifery and Gynæcology.

W. H. Barker	F. R. Lambert
J. P. Bull	J. D. Scott
N. B. Finter	E. P. H. Shortt

PART II.

Principles and Practice of Physic, Pathology and Pharmacology.

A. P. Baker	M. H. Lessof
E. M. M. Besterman	J. G. Mathewson
G. T. F. Braddock	T. C. L. Parry
I. W. Burmford	J. F. F. Rooney
J. Crossley	W. B. Webb

CHANGE OF ADDRESS

M. J. F. McArdle, M.B., B.S., 17, Spencer Hill, Wimbledon, S.W.19, and 58a, Wimpole Street, W.1. (Tel. : Wimbledon 0711 and Welbeck 4545.)

BIRTHS

DAVIES.—On December 11th, 1946, in Nuffield House, to Helen (née Macdonald Bishop), wife of Paul Davies—a daughter, Gwenda Macdonald.

NICHOLAS.—On Boxing Day, 1946, at Cedar Court Nursing Home, to Margaret and Charles P. Nicholas—a daughter.

TULLEY.—On December 30th, 1946, to Eileen (née Jeffreys), wife of Jack Tully—a daughter.

MARRIAGE

NEVE—HUNT.—On December 14th, 1946, at St. James' Church, Wiscombe, Richard Neve, M.B., B.S., to Elizabeth Lilian Hunt, of Oakridge, Wiscombe, Somerset.

Eds. { D.H.F. / H.A.R.

GUY'S HOSPITAL GAZETTE

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PASSIM

IT'S all very difficult. Of what should Passim speak? With monotonous regularity comes the reply (always the same meaning, usually the same simile), "It should reflect, like a mirror, the activities and opinions of the Hospital." But all the Hospital activities of any interest are recorded in the main body of the *Gazette* and to report on those that are of so little import as not to acquire notice there, would make this page nothing short of a diary of petty occasions. "Domino tournament in Nuffield Nurses' Home"? "Grand beer-up in Residents' Room on Twelfth Night"? Or even the more intimate "Doctor weds nurse" or "Nurse wins doctor" touch? No, there's nothing left after the reporters, article writers and correspondents have had their pick. How about opinions? Can one 'reflect' opinions with any fairness? He would be a dull soul who could record in print opinions for which he held no brief. (Perhaps he is a dull soul. But not that dull he trusts). It could be simply editorial opinion. It would be fun while it lasted. Quite obviously one must buy an Osler and an Alice in Wonderland, a reprint of all the speeches of Mr. Aneurin Bevan and a collection of the sayings of the one time Honorary Surgeon who always "used to say," and lead on from there with quotations interspersed with paraphrase. But it's still all very difficult.

The season of changing firms is upon us, of dressers' dinners and of deep imbibing, of loss of pedestals, and of christian names, and of saying good-bye. A moment too for looking over our shoulders. Another step. A successful and profitable step we hope, not just another three months done, another sign-up and another dead yesterday.

Who hasn't piped up on an afternoon round, after a too swift return from a too distant dream, for all the world (or so it seemed) to hear his folly? Not many. Who hasn't held his silence at a moment when, had he given tongue to his bright notion, the laurels, the halo and the everlasting glory would have been his? Not so many, but not so few. But are those the features of the past appointment which will be remembered and recounted in years to come when we tell old friends, re-met, or the bored offspring we beget, of "when I was on with Old So-and-so?" What will stick?

We may have seen our first typical case of this or rare case of that, or learnt to carry out some technical manœuvre which so far had escaped us. We may feel that quietly and unobtrusively, bit by bit, in the past three months there has been an expansion between the ears, a steady absorption of knowledge.

Our Honorary may have dropped one real pearl, or our Registrar two real bricks. They might make quite good telling. But the mirror revolves anti-clockwise and for a moment reflects clearly :—

" I saw a case at Out-Patients. I still don't know what the diagnosis was, but she was a very unhappy woman. I can't even remember her history, but I do remember that the doctor listened to her with great patience, although she was the last case, and it was already late. It was a very long story, because she was so very worried, but it didn't seem to lead anywhere. She eventually came to the end of it, and said that she already felt better for having got it off her chest. I thought it was a clear case for a tonic, and being the last there I made preparations to slip away. But the doctor started asking her questions, trying to find some thread, as it were, on which to string her miscellaneous collection of symptoms. Then he asked her to undress and get on the couch, and he examined her as carefully as if she had some exciting disease. He spent a long time, and in the end he had collected a few signs. I cannot remember what they were, but I know that all he wanted for his diagnosis was a little ketone in the urine. Not very much. Just a trace. So I tested it for him. There it was, just a trace, and I showed it to him. He looked at it against the light. He looked at it against the dark. He took some himself and tested it again. " No," he said with a sigh. There were no ketones. So he told her to dress up, and he sat with his head in his hands and thought. I so badly wanted to suggest a tonic for the patient and lunch for ourselves. Then she came and sat down, and he said, " Madam, I don't know what is wrong with you, but if you will come back in a week's time I will try again."

Well I don't know what happened to her. I wasn't there the next week. But I shall remember in years to come, of " When I was on with Old So-and-so." And what shall I recount ? The history, the signs and the diagnosis ? I can remember none of them. The doctor's good manners in listening so patiently ? The enquiring mind he had, ferreting on, when a tonic might have sufficed ? His intellectual honesty in denying the presence of ketones ? His humility in admitting he didn't know, or his moral courage in asking her to come back in a week ? No, none of these things. I shall recall his great kindness."

On behalf of our readers we welcome Dr. T. A. H. Munro who has recently been appointed to the Hospital Staff as Director of York Clinic.

We hasten to correct here a printing error which occurred in the editorial note to the letter, " The Hospital and the Future," in the December 21st issue of the *Gazette*. The correct note referred to the " Ship and Shovel " as " a most intimate part of the Hospital *de facto* if not *de jure* " and not, as the printed result unfortunately implied, as " part of the Hospital defects ! "

We would remind our readers that the annual subscription to the *Gazette*, 12*s*. 6*d*. per annum, post free, including the " Directory of Guy's Men (Medical and Dental), as and when published, is now due and should be forwarded to the Manager, The Gazette Office, Guy's Hospital, S.E.1.

Penicillin in the Treatment of Venereal Disease

A Clinical Lecture given by V. E. LLOYD on 25th July, 1946.

1. *Gonorrhœa.*

PENICILLIN was used for the treatment of acute gonorrhœa in the male urethra within a short time of the susceptibility of the gonococcus to this agent being reported.

In the early attempts at treatment sodium penicillin was given by the continuous intravenous drip method in vogue at that time for other infections. This method was soon replaced by intermittent treatment given in multiple regularly spaced intramuscular injections. At first the dosage was modest in amount and the period of treatment spread over 2–3 days. Later it became evident that equally good results could be obtained with a larger total dosage given in a shorter time period and the dosage was increased from 5,000 up to 10,000 units given at 3 hourly intervals over a period of 24–36 hours. In the British Army in the Middle East, Lees reported 98 per cent. apparent cures after 10 injections of 10,000 units at 3 hour intervals.

At this time the supply of penicillin available for use in gonorrhœa was almost entirely restricted to military hospitals, in which the heavy demand for bed accommodation by casualties soon led to the development of a condensed course of 100,000–150,000 units, given in 3–5 injections at intervals of 2–3 hours—a schedule which could be completed in one day.

Some of the results of these many trials of variation in the number of injections and in the time interval may be seen in the accompanying Table compiled from various published reports.

Results of the multiple injection treatment of gonorrhœa with aqueous solutions of sodium penicillin.

No. of cases	Total number of units	No. of injections	Interval between injections in hours	Per cent. cured	Author
50	30,000	3	3	80	Lees, British Army
1,383	60,000	6	3	94.3	
50	100,000	2	8	78	Laird, British Army
53	100,000	3	3	85	
52	100,000	5	3	96	
52	100,000	5	2	98	
265	150,000	5	2	99	Lloyd Jones, Maitland & Allen, British Navy
190	200,000	2	6–8	95.8	Gillick & Chin, U.S. Army
95	200,000	4	1	95	Batchelor, Donald & Maitland, Edinburgh

Although good results were consistently obtained in military patients with this schedule, it was found to have imperfections as soon as penicillin was released for the use of civil clinics. The long detention of out-patients over many hours, although it had the advantage of avoiding the necessity of admissions into hospital beds, nevertheless proved irksome to patients and staff in the whole-time clinics serving civilians and impracticable for many of the smaller clinics which are open for only a few hours each week.

A single injection treatment of high efficiency for gonorrhœa was an ideal which had been envisaged by many venereologists, but its realization had been prevented by the rapidity of the excretion of penicillin through the kidneys and the resulting brevity of its action in the tissues. Many possible methods of delaying the excretion of penicillin have been investigated. The simultaneous injection of para-aminohippuric acid, for example, causes a delay in excretion and thus prevents the rapid fall of the level of penicillin in the blood-serum. Benzoic acid given by the mouth together with a restricted fluid intake also delays the excretion of penicillin. Chilling the tissues by ice packs at the site of injections is an effective method of obtaining slow absorption and delayed excretion.

Most of the attempts to slow down the rapid rate of excretion have been directed to the discovery of some solvent or medium suitable for the incorporation of penicillin to be given by intramuscular injection which would effect a slow release from the site of injection and a slow absorption and, therefore, a more steadily maintained blood level. Many substances, *e.g.* gelatin, dextrose, adrenaline, aluminium hydroxide, magnesium sulphate and numerous oils, have been utilised in this manner with some success.

An effective and the most popular medium is that advocated by Romansky and Rittman, who incorporated calcium penicillin in a small quantity of beeswax suspended in arachis oil.

The penicillin-oil-beeswax suspensions contain calcium penicillin which is less hygroscopic and which is more stable than is sodium penicillin. The proportion of beeswax varies from 3–5 per cent., and the amount of penicillin originally 50,000 units per cubic centimetre is now obtainable in a concentration as high as 125,000 units per cubic centimetre of the suspension.

The subsequent level of penicillin in the blood serum after one intramuscular injection although modest in amount is maintained for 18–24 hours and apparently ensures a continuous although not intense action. The result of a single injection of 200,000–250,000 units of calcium penicillin in this oil-wax medium when given for acute gonorrhœa appears to be as good as that obtained from multiple 3-hourly injections of sodium penicillin spread over 15–30 hours. This method has therefore been adopted widely by civil hospitals and clinics, for the treatment of acute gonorrhœa at one visit. Here, at Guy's, we give one injection of 250,000 units of calcium penicillin incorporated in beeswax and suspended in ethyl oleate.

In men the proportion of cures reported is as high as 92 per cent. after a single injection of 200,000 units (Van Slyke and Heller). Similar results are reported by Thomas in the treatment of gonorrhœa in women. Gonococcal vulvo-vaginitis in children appears somewhat less amenable to this treatment.

Penicillin therapy seems to be just as effective in gonoccal infections which have resisted sulphonamide treatment as it is in the recent untreated infection. Although there are some failures to achieve rapid cure in both of these types of infection there is little, if any, definite evidence for the existence of natural or acquired penicillin-resistant strains of gonococcus. Infections which have apparently resisted treatment with penicillin will often respond to additional penicillin injections ; treatment with a sulphonamide compound is also likely to be efficacious in cases which do not respond favourably to penicillin.

Ophthalmia neonatorum of gonococcal origin responds to sodium penicillin in aqueous solution given by 3-hourly intramuscular injections ; it also is readily controlled by very frequently repeated conjunctival instillations of a 1 in 5,000 solution maintained for 48 hours.

The value of penicillin and the most efficient method of using it in the various complications due to the local extension of gonococcal infection are not yet settled. Prostatitis, epididymitis, salpingitis do not respond at all speedily to one or two injections of penicillin. Gonococcal arthritis responds so feebly to penicillin that it is customary to maintain continuous therapy for several days or even a week. Possibly

this lack of response in arthritis is due to the relatively low penetration of penicillin into the synovial cavity. This suggestion is by no means a complete explanation, because gonococcal infection of joints particularly when in the early acute stage is almost entirely peri-articular in situation, where one would imagine that the penetration of penicillin should be in normal amount. No doubt other unknown factors are concerned.

Assessment of cure.

Acute gonococcal infection is readily and promptly controlled by penicillin treatment in a high proportion of cases. All symptoms and signs in many patients will disappear within 24 hours. This somewhat miraculous response has lead inevitably to an uncritical attitude in the assessment of cure. However, the slow response or lack of response to penicillin therapy of such complications of gonorrhœa as prostatitis, epididymitis, salpingitis and arthritis, together with the early relapse rate of about 5–10 per cent. of uncomplicated infections suggests caution in any easy assumption of cure in the apparently responsive cases.

In some of the cases of acute urethritis treated with penicillin a slight abacterial discharge may persist for a few days or weeks. The manifest failures are of course easily recognised for the gonococcus is still present, but it is a difficult matter to ascertain whether a persistant mild gleet is due to the presence of a few remaining gonococci or not. In some of these cases of slight urethral gleet, often seen by the patient only on awakening after a night's sleep, a frank relapse with a profuse discharge develops after some weeks. Consequently, it is most inadvisable to reduce either the former standard of cure or the period of observation subsequent to treatment. This period should be for at least two months during which repeated bacteriological tests are done on any discharge or urinary debris which may be present; also upon the prostatic fluid expressed by digital massage.

Our present dosage of penicillin in gonorrhœa, 250,000 units, is probably capable of delaying the appearance of concomitantly acquired syphilis. A physical examination of the patient from this aspect is therefore advisable at the end of 3 and 6 months after treatment. A Wassermann reaction should also be done at the same time.

2. *Primary and secondary syphilis.*

The story of the use of penicillin in syphilis begins in 1943 with the work of Lourie and Collier in the laboratories of the Liverpool School of Tropical Medicine, where it was shown that penicillin was effective in the treatment of experimental infection with *spirochæta recurrentis* and with *spirillum minus* in mice. Lourie and Collier, in their report, foreshadowed the early use of penicillin as an antisyphilitic agent. In December, 1943, in the United States of America, Mahoney, Arnold and Harris, following preliminary experiments which had demonstrated a rapid action of penicillin on experimental syphilitic lesions in rabbits, reported its successful effect in four cases of primary syphilis in man.

Many cases of early syphilis (primary and secondary stages) in man have been treated since 1943, and we now have accumulated much information concerning the immediate effect of penicillin upon these early lesions. There is no doubt that penicillin even in modest dosage, will effect a rapid healing of the early infectious lesions of syphilis. Spirochætes disappear from the secretion of a primary syphilitic sore within 16 hours or so—a remarkable speed and certainly as quickly and perhaps more rapidly than after the injection of neoarsphenamine.

After the use of penicillin the progression of active syphilitic ulceration soon becomes arrested and a healthy granulating base is apparent in the ulcer within 2–3 days. Ultimate healing, however, although sound enough, seems a little slower than that which we are accustomed to see after the injection of neoarsphenamine. The intensity of the Wassermann reaction in the cases positive before treatment appears to wane at about the same rate as it does after treatment with necarsphenamine; the reaction does not often become negative under 3 months. The immediate effect of penicillin in producing rapid sterilization and speedy resolution, and healing of infective syphilitic lesions is obviously of inestimable value to the public health.

So far so good; but we need much more than a temporary healing action from a new antisyphilitic remedy. Syphilitic lesions will also heal rapidly after only a few injections of an organic arsenical compound or even of a bismuth preparation; but we know only too well that if additional regularly spaced injections of these remedies are not given the recently healed sore is apt to break open and yield a secretion

heavily laden with spirochætes. It was quickly realised that penicillin therapy for syphilis to be effective must be continued for some considerable time, and that on account of the rapid excretion of penicillin by the kidneys repeated injections at every third hour would be necessary to maintain an appreciable blood-level of penicillin.

Widespread trials of this new antibiotic in syphilis were undertaken in the United States of America in 1944, in order to ascertain the best method of using it. Preliminary trials soon led to a prolongation of the period of treatment to 7–8 days. Much work had to be done to establish an effective dosage. Table 1 shows the short-term results obtained in these range-finding trials of penicillin dosage in three-hourly intramuscular injections, spread evenly over a standard period of 7½ days.

TABLE 1.—Effect of repeated injections of aqueous sodium penicillin on early syphilitic lesions.*

Total penicillin units	Interval	Length of treatment	Relapse within eleven months
60,000	3 hours	7½ days	62 per cent. of cases
300,000	,,	,,	42 ,, ,,
600,000	,,	,,	26 ,, ,,
1,200,000	,,	,,	18 ,, ,,
2,400,000	,,	,,	15 ,, ,,
4,800,000	,,	15 days	Not yet ascertained

* From the report of the Committee on Medical Research and the United States Public Health Service, 1946.

The effects of penicillin through this wide range of total dosage indicate that, using a standard time period of 7½ days, better results are achieved by increasing the total dosage. It is, however, important to note that doubling the total dosage does not reduce proportionately the frequency of relapse. In fact, in order to reduce the proportion of relapsing cases to less than one-fifth it has been necessary to make a forty-fold increase in the amount of penicillin.

The high incidence of relapse among the cases treated with the smaller number of total units soon led to the disuse of these amounts. A large number of cases were treated with a total of 1,200,000 units which seemed to give more promising results, but the eventual proportion of relapses—18 per cent.—led to a further increase in dosage.

The better results yielded by the 2,400,000 unit schedule led to the adoption of that total as the standard schedule of treatment in the armed services of the United States, and in some commands of the British Army in 1944.

The incidence of relapse after this schedule in British Army cases is reported by Marshall to be 15 per cent in cases observed for 6 months.

Up to this time little or no penicillin had been released for use in cases of syphilis in civilians. However, as soon as penicillin became available to civil venereal disease clinics it was realised that treatment with penicillin given by three-hourly injections over a period of 7½ days was impracticable for civilians, chiefly on account of the insufficient number of beds in hospitals, but also of the refusal of civil patients to enter hospitals when a bed was available.

It therefore became imperative to develop some method of giving penicillin which would maintain a prolonged adequate blood level of this compound and which would avoid the necessity of detention of the patient in hospital.

Attempts were made to compress the treatment into a much shorter time period, using the same dosage and using a much higher dosage. It is clear from the data shown in Table II that in the short time-periods even a very large dosage has in most instances only a temporary effect. It seems that short-period treatment for syphilis whatever the dosage used, as in sub-acute bacterial endocarditis and in actinomycosis, is unlikely to be successful.

TABLE II.—Effect of short-period large-dose penicillin treatment of cases of early syphilis.

Duration of treatment	Total number of units	Individual dose in units	Number of injections	Result
5 days	5,000,000	1,000,000	5	50 per cent. relapse
3 days	3,000,000	1,000,000	3	50 per cent. relapse
2 days	5,000,000	various	?	75 per cent. relapse
2 days	2,400,000	200,000	12	Unsatisfactory
8 hours	1,200,000	150,000	8	Unsatisfactory
3 hours	5,000,000	various	?	4 cases ; all relapsed
3 hours	7,000,000	various	?	1 case only ; relapsed

A composite table compiled from the reports of (1) Lloyd Jones, T. R. ; Allen, S. J., and Donaldson, E. M. (1946), *Brit. Med. J.*, **1**, 567 ; and (2) Lowrie, E. M. ; Collier, W. J. ; Ross, A. O. F. ; Nelson, B. R. ; and Robinson, D. T. (1946), *Lancet*, **2**, 696.

This failure of short-term treatment is not surprising. We meet with the same experience in the use of penicillin for infections with pyogenic bacteria. In the treatment of the severe infections with the hæmolytic streptococcus or staphylococcus aureous we learnt quickly that penicillin therapy must be maintained regularly for a considerable period after apparent cure has been achieved if relapse is to be avoided. Also the intervals between injections must be so adjusted to the individual dose that an adequate blood-level of penicillin is steadily maintained.

There is little doubt that susceptible organisms in the phase of rapid multiplication are soon dealt with by penicillin ; but those organisms in the resting phase are insusceptible to its action.

The very frequent occurrence of the Herxheimer reaction in cases of syphilis treated with penicillin suggests most vividly that very many spirochætes are killed in the first 12–24 hours after the commencement of penicillin therapy, even when this has been of modest dosage. This reaction, which is a well-known but not very common occurrence after treatment with neoarsphenamine, comprises a temporary exacerbation of the syphilitic sore or rash together with malaise and fever within the first 24 hours of treatment. It is much more frequently noted after penicillin therapy.

Parallel with the attempts to control syphilis with a high dosage of penicillin given over a short time period, other attempts have been made to evolve methods of restricting its rapid absorption and excretion. The most practical of these methods, in its application to ambulant cases of syphilis, is the use of a suspension of calcium penicillin in beeswax in oil which now can be obtained in a concentration of 125,000 units per cubic centimetre. From this suspension, which is administered by intramuscular injection, the calcium penicillin is absorbed slowly but at a fairly constant rate. The resultant blood-level of penicillin is somewhat low in comparison with that obtained by the injection of aqueous sodium penicillin, but it is maintained for a much longer period—18–24 hours. The ideal of a method of treatment suitable for outpatients and limited to one daily injection has therefore probably been attained.

Now, after the first flush of enthusiasm at the striking effect of penicillin in syphilis has begun to wane, there appears to be some dissatisfaction at its inability—in the various dosages and time periods used up to date—to achieve success in every case. The arsphenamine compounds which had been almost completely superseded by penicillin in the United States of America are now taking their place once again in the schedules of syphilis treatment. In the combined penicillin-arsphenamine treatment schedules, penicillin is given over a period of 7–8 days. Injections of the arsphenamine compound are commenced during the penicillin treatment and continued for another 4–8 weeks.

In the civil venereal disease clinics in Great Britain much of the data given above was known before penicillin was freely available for the treatment of syphilis. So, at the present time in the venereal disease clinic in this hospital, the standard treatment of patients with early syphilis, attending as out-patients, is by injections of 300,000 units of calcium penicillin, in a beeswax-oil medium, given once daily for 8 days. Neoarsphenamine is given twice weekly during the first week and thereafter at weekly intervals together with bismuth during an additional seven weeks.

The story of the use of penicillin as an antisyphilitic agent bears a strong resemblance to that of Ehrlich's salvarsan—high hopes followed by checks and disappointments. It will be obvious to you all that much work remains to be done—data that

may take years to collect and elucidate—before the ultimate value of penicillin in in syphilis is fully assessed.

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van Slyke, C. J. and Heller, J. R. (1945). *J. Vener. Dis. Inform.*, **26**, 98.

Resident Course in Fevers

INFECTIOUS diseases are rarely seen, even in the out-patient department of a General Hospital, with the result that the average student must rely entirely on a textbook knowledge, assisted little, if at all, by a routine course of lectures.

We were fortunate in being the first group of Guy's students to take advantage of the new Resident Course offered at the Park Hospital, Hither Green. No statement of ours can possibly do it full justice, for not only were we given the opportunity of seeing every type of infectious disease but we were also treated with the greatest consideration and understanding.

We have come back with a full realisation of the part played by these diseases, both as " killers " in infancy and also as a foundation for many of the chronic maladies of later life. The teaching was essentially practical and of an extremely high standard, succeeding in that difficult task of making us really interested in the prophylaxis and after-care of the cases, as well as in their initial diagnosis. The Medical and Nursing Staffs endeavoured to show us everything which might be of any value to us, and we were given every possible help and encouragement when examining cases. We were called to see all patients on admission and this, combined with a system of later " follow ups " in the wards, enabled us to see all stages of a disease, including the elusive Koplik spot or the evanescent rash. It is impossible to catalogue all the cases we examined, suffice it to say that we were able to see at least one of every condition we had hoped to be shown, including many variations of onset and complications. Examples of the other cases we examined are those of a classical case of leprosy, a small boy with Mediterranean Kala-azar and a T.B. meningitis following an infection of the dorsal vertebræ.

The importance of quick and, more particularly, accurate diagnosis was impressed upon us by the large number of general medical cases erroneously notified as infectious diseases and also by several cases of enteric fever which, previously labelled as P.U.O., had lain sometimes for weeks in the wards of general hospitals.

It was one of the most profitable fortnights that we have spent during our clinical period, and we hope that by writing this short article we shall not only bring it to the notice of those who are eligible to go, but also convey our appreciation to those both at Guy's and at " the Park " who have organised it.

T. E. OPPÉ. J. H. APTED. A. SHUTE.
J. L. HARDMAN. G. F. VAUGHAN.

"Hay Fever"

(Presented by the Guy's Theatre Club in the Physiology Theatre, December, 1946.)

ON the whole, it is the female rôles which suffer most in amateur theatricals; so it was a daring venture to present a piece in which the central character is an ageing actress for were this performance to fail, the play could not but become boring and meaningless. However, this did not occur for, as the brilliant, charming, unpredictable Judith, Miss ROWENA SANDERS gave a most assured and convincing performance. She gave to her part all the controlled charm which Coward must have had in mind when he wrote it. Her playing throughout the domestic entanglements of the second Act was particularly pleasing. The surprising thing was that she had been made up to look so young: surely the rearing of two grown-up children and the vicissitudes of a life on the stage could not leave even Judith with features so clear and unlined? But for all that, Miss SANDERS was so much in character that one was disappointed that she did not, in fact, play the piano and sing to us—one feels that it would have been a unique experience. It was, in fact, a carefully studied and polished performance such as is not often seen on the amateur stage.

The remaining parts were necessarily subordinate but were, on the whole, well done. Mr. JOHN HAYWARD gave a pleasantly abstracted performance as Judith's bookish husband, with a delightful outburst of nonchalant lechery in the second Act. Mr. BERNARD MALLETT, as Simon, Judith's son, was sufficiently cynical and sophisticated and retained enough boyishness to make his jejune attachments credible. Miss JEAN THOMAS (Sorel Bliss) gave her usual unobtrusive and well-polished performance. As the naive Sandy Tyrell, Mr. DAVID BUSH was pleasantly ingenuous but his performance was to some extent marred by a tendency to over-play. Miss MARY WILLIS, as the coy Jackie Coryton, also tended to over-act, but she gave a good performance in what must be a difficult part. Miss JOCELINE MORRISON seemed uneasy as Myra Arundel—as well she might do, since the part, as written, hovers uncertainly between great sophistication and a rather conventional attitude. Finally, Mr. RODNEY LONG was wholly admirable as the suave and dignified Richard Greatham. The diplomatic surprise with which he watched the barometer fall was the funniest moment of the evening. He even managed to kiss the back of Judith's neck without losing any of the touch of the grand seigneur. This was a very effective performance.

The production, on which so much in this play depends, was excellent, and Mr. MICHAEL COPLANS handled the players very well within the narrow confines of the stage. In particular, one should praise his management of the last Act, where the pace and precision were particularly good. A word of praise should also be given to the make-up artist, Mr. JOHN STREET, whose results were far ahead of those of previous productions.

D. O.

STUDENT TYPES

V. CONVIVIAL

Poem

" We march with the times " Ay the Governors of Guy's
" With feminine students galore-o,"
The Sectorarchs' cries are to " Nationalize !
Our Sector will be to the fore-o."

The Department of Works say to any who shirks
Or who privily skulks from his chore-o
" No man will here lurk who plays us these quirks.
Closed Shop ! Jao ! Pede Decoro."

But—a rift in the lute—the female repute
For Reaction is yet to the fore-o
The Nurses' Home. Moot does Progress refute,
Exclusively She, evermore-o.

" The P.T.S. floors to be trod by those boors
Of Males ! " They'd puff like the porpoise
" We open our doors to co-ed Paramours,
Male Lambs ! No Trans mortuum Corpus ! "

ANON.

Correspondence

Carol Singing

SIR,—We beg the hospitality of your columns to inform those that took part in the carol singing on December 23rd of the results.

The enjoyable evening was rewarded by the taking of £63 17*s.* and the inevitable button.

From this toys for an unexpected visit from Father Christmas complete with " Reindeer " was provided, some lost carol books replaced, and the balance of £54 paid into the children's ward account.

Our heartiest thanks to all who made it possible.

Yours, etc.,

Guy's Hospital, S.E.1. I.S., M.C.

Review

The Human Approach. By HENRY YELLOWLEES. First Edition. J. & A. Churchill, Ltd. *Price* 10*s.* 6*d.*

THE author sets out in this book to impress upon the student who has recently left the cadaver, that if he is to learn anything of use or do anything of good he will have to regard his patients as something other than a background for the investigation of organic pathology; he will have to credit them with individuality. In his preclinical days the student has been potting at a sitting target; in his clinical days he will be hunting a moving one. He will still be using the same shot—the scientific approach—but this, be the aim never so steady, will no longer be enough. From now on he will require something else—an understanding of the vagaries of his game.

This is a remarkable book, easy to read, interesting, amusing, informative and most opportune. It displays a profound understanding of human nature. It can be thoroughly recommended to those for whom it is intended, and to those who find appeal in the title. Of no use to those struggling with examinations, it will be of enormous help to anyone embarking on that frightening ordeal—their first examination of a live patient.

H.A.R.

Sport

RUGBY

GUY'S *v.* OLD CRANLEIGHANS.

(*Played at H.O.P., Saturday, Dec. 14th.*)

Result: Guy's 29, Old Cranleighans 3.

By way of a change the home supporters had the pleasure of seeing Guy's pile up a big score and their victory by 4 goals and 3 tries to a penalty goal against the Old Cranleighans did ample justice to a stylish display.

Visibility, owing to fog, was poor at the start but it was possible to follow the game throughout without difficulty. The Hospital monopolised the scrums and gave the backs opportunities of indulging in some delightful movements, and the fact that six of the tries came from them gives some idea of their marked superiority. The handling was clean and accurate, and they were quick in cutting huge gaps in the Old Boys' defence. The return of F. le Clus at left centre was marked by a brilliant display by himself, D. M. Strathie and F. van der Westhuizen.

Guy's led at the interval by 8 points to nil.

D. M. Strathie made a brilliant cut through and sent F. van der Westhuizen over for T. L. T. Lewis to convert, and another try was scored by F. le Clus who completely baffled the Old Boys by a deceptive run. Following the interval, D. M. Strathie ran half the length of the field in grand style for a try and T. L. T. Lewis converted. D. N. H. Owen ran in and round to the posts but this time Lewis failed with the kick, and then the Cranleighans gained their solitary score with a penalty goal by N. Black.

J. Keeling, who had been hooking the ball persistently throughout the game, was credited with a try and again T. L. T. Lewis converted, but the big shout of the game came when D. le Clus converted his own try from the touch-line, which appeared an impossible task considering the heavy state of the ground. Finally, F. le Clus scored another good try but this time his brother just failed with the kick.

HOCKEY.

GUY'S *v.* HAWKS.

(Lost 9—4)

It was with some trepidation that Guy's played the Hawks on November 31st, for not only were our opponents a very strong side, but also their team included L. D. Carton-Kelly, our last season's captain.

On a wet ground, but with the sun shining, Guy's made a promising start. Attacking at once, and swinging the ball well, we pressed hard for the first ten minutes, Kelsey Fry eventually scoring off a well-timed shot. Disaster was to follow, for Hawks replied by scoring three goals in five minutes; this was followed by another goal, from a penalty bully, and then by three more goals making the half-time score 7—1.

In the second half our defence became more settled, and thanks to the capriciousness of the Hawks right back, our attack met with more success. S. R. Earl, dribbling somewhat unconventionally for half the length of the field, scored for Guy's and although the Hawks scored twice more, so did we, and the final score was 9—4.

The game was a severe test for our team, showing up our faults only too clearly. The defence was drawn too readily, and was palpably ignorant of the technique of the wrong side tackle; the forwards were too slow, and dribbled far too long, but it is to their credit that few other teams have scored as many goals against the Hawks on their own ground.

Team: F. H. Walker, H. Carter, G. H. Danford, R. A. Keable-Elliott, E. A. Murray, J. B. Harris, D. V. Duckworth, I. Kelsey Fry (Captain), R. L. Barnard, S. S. R. Earl, K. Y. Khong.

ICE HOCKEY

During the last year ice hockey has become increasingly popular throughout the country, and this has also found its echo at Guy's. Every effort is being made by some keen players at the Hospital to re-form the Ice-Hockey Club after its enforced cessation during the war.

The Club was originally founded in 1935 by R. J. Simms, a Canadian, and very soon came to play a large and popular part in the Hospital activities. There are accounts in *Gazettes* during the pre-war years of many very exciting matches at Harringay Stadium and of enthusiastic crowds of spectators. St. Thomas's and Guy's were the only Hospitals in London to function and were responsible in forming a United Hospitals side which provided keen competition. Guy's played a large part in this inter-hospital team and matches were played against Oxford, Cambridge, and well-known rink teams.

Just before the war the Ice-Hockey Club was affiliated to the Clubs' Union, Mr. E. G. Slesinger was its President and his efforts contributed largely to the success of the Club.

During the war all functions of the Club ceased as many rinks were requisitioned for war purposes, and few were open to the public. This position has improved to such an extent that it has been possible to re-start. Training and instruction in Ice-Hockey has been arranged and facilities for matches will be provided at Streatham and at Harringay Stadium. We hope to be really strong by the end of January and everyone who is interested and able to play is invited to join us, by getting in touch with me.

H. A. H. OHLRICH.

Hospital Information, etc.

NOTICES

DEPARTMENT OF SURGERY

On Saturday, January 25th, at 10.30 a.m., there will be a clinico-pathological demonstration in the Clinical Theatre (Guy's House). Recent cases of pathological interest will be discussed.

On Saturday, February 1st, at 10.30 a.m., there will be a conducted tour of the portraits in the Royal College of Surgeons. Those wishing to attend are asked to give their names to the Director. The party will be limited to twelve and applicants are asked to state whether they will be bringing a friend (of either sex). If required another tour will be arranged at a later date.

A Surgical Departmental Library has been started and is temporarily housed in the Surgeons' Room. Books and periodicals are available for inspection on any day before 10.0 a.m., but must on no account be removed.

An additional demonstration in the series of standard surgical procedures will be held at midday on Tuesday, January 21st.

H. J. B. ATKINS,
Director of the Surgical Department.

PASS LIST

SOCIETY OF APOTHECARIES OF LONDON.

FINAL EXAMINATION.

December, 1946.

Surgery.—*S. L. O. Jackson, *J. O. Kelsey.

Pathology, Bacteriology and Forensic Medicine.—*H. Freeman, R. D. C. Hart.

Midwifery.—*S. L. O. Jackson.

* Have now completed the examination.

November, 1946.

Pathology, Bacteriology and Forensic Medicine.—S. L. O. Jackson.

Medicine.—S. L. O. Jackson.

CONJOINT BOARD.

FIRST EXAMINATION.

L.R.C.P., M.R.C.S.

December, 1946.

Anatomy.

J. R. Evans — A. M. Platt
A. P. T. Van Hamel — K. I. Porges

Physiology.

J. R. Evans — J. B. Parsons
J. P. Garrett — A. M. Platt
A. V. Gledhill — K. I. Porges
J. L. Harrington

Pharmacology.

K. A. Baker — H. W. G. Loudon
K. M. Citron — J. B. Morrison
N. Davis — D. M. Rahilly
D. H. Griffiths — J. Rankin
J. M. Hall — H. R. C. Riches
E. Killey — D. J. R. Snow

CONJOINT BOARD.

December, 1946.

Chemistry.

H. G. Carr — W. C. Porter
C. L. Celestin — P. Readings
J. G. G. Dixon — G. S. Rose
G. D. Gibb — P. A. Swift
N. I. Lewis — R. L. G. Thornton
D. London — D. R. Whittington
F. R. B. Matthias

Physics.

W. H. Legg — J. J. F. Staub
J. G. Levenson — C. A. P. Steele
M. Lovett — G. A. Swift
N. J. Mayson

Biology.

C. J. Bayley — F. Quail
D. R. Burnapp — P. Readings
T. B. Forward — G. S. Rose
N. I. Lewis — C. A. P. Steele
F. R. B. Matthias — P. A. Swift
R. E. W. Pearce — E. Tweddle

CONJOINT BOARD.

L.R.C.P., M.R.C.S.

FINAL EXAMINATION.

December, 1946.

Anatomy.

R. D. Hernaman-Johnson

ROYAL COLLEGE OF SURGEONS.

F.R.C.S.

FINAL EXAMINATION.

December, 1946.

R. G. Robinson — C. O. Fung-Kee-Fung

UNIVERSITY OF LONDON.

FACULTY OF SCIENCE.

INTERMEDIATE EXAMINATION.

November, 1946.

The following student has completed the External Intermediate Science.

H. Gold.

UNIVERSITY OF LONDON.

M.D.

December, 1946.

Branch I. (Medicine).

R. D. Blachford — R. I. McCallum
A. Bloom — A. T. M. Roberts
W. Fine — D. Stafford-Clark
D. C. Lewin

Branch IV.
Midwifery and Diseases of Women.

D. A. Davies.

Branch VI.—Tropical Medicine.

S. W. Hinds.

UNIVERSITY OF LONDON.
GENERAL FIRST EXAMINATION FOR MEDICAL DEGREES.
December, 1946.

B. Bilton — D. W. L. Phillips
F. J. Covill — J. A. Rycroft
I. M. Jones — J. S. Tisdall
V. R. Jones

The following Higher School Candidates have completed exemption from the First Medical.

D. R. Burnapp — G. L. Shaw
W. V. James — R. J. Shephard
E. T. Johns — R. V. Steward

UNIVERSITY OF LONDON.
FIRST EXAMINATION FOR MEDICAL DEGREES.
December, 1946.
A. I. Fram.

UNIVERSITY OF LONDON.
THIRD (B.D.S.) EXAMINATION IN DENTAL SURGERY.
December, 1946.
Pass.
D. G. Jones — B. W. Pett — A. Stone
Supplementary Pass List.
H. M. Hughes.

SECOND EXAMINATION IN DENTAL SURGERY.
PART I.
December, 1946.
B. G. E. Donner — S. R. W. Powell
S. P. Gill — B. H. Wilshere

The following Students are credited with Anatomy and Physiology.
P. J. Holloway — B. E. Lawson — R. Marx

PART II.
J. D. Derry — R. L. Leader
J. C. Farrow — A. H. R. Rowe

UNIVERSITY OF OXFORD.

DEGREES OF BACHELOR OF MEDICINE AND BACHELOR OF SURGERY.
Medicine, Surgery and Midwifery.
December, 1946.
M. G. D. Davys — R. E. A. Hansen

The degree of Bachelor of Medicine has been conferred on M. G. D. Davys.

PAPERS BY GUY'S MEN

Jarman, Ronald. History of intravenous anæsthesia with ten years' experience in the use of pentothal sodium. *Post-Grad., Med. J.*, 1946, **32**, 311.

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Marston, A. D. A short survey of the life and work of Joseph Clover. *Med. J.*, 1946, **216**, 455.

Forman, L. Darier's disease and generalized pruritus. *Proc. Roy. Soc. Med.*, 1946-7, **40**, 8.

Marre, I. R. Effect of Calciferol on Lupus Vulgaris (two cases), Lupus Pernio and Boeck's sarcoid. *Ibid.*, 10.

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Ogilvie, Sir Heneage. Diagnosis and decision in acute abdominal emergencies. *Pract.*, 1947, **158**, 2.

Cathie, I. A. B. Rhesus incompatibility. *Ibid.*, 47.

Marre, T. R. The general treatment of skin diseases. *Post-Grad. Med. J.*, 1947, **23**, 49.

CHANGES OF ADDRESS

T. H. Hills, M.B., B.S., The Mill House, Four Elms, Edenbridge, Kent. (Tel.: Four Elms 70.)

W. Hopkin-Jones, M.R.C.S., L.D.S., 48, Welbeck Street, W.1. (Tel.: Welbeck 5221.)

Lance O'Neill Fox, F.R.C.S., 521, Colonial Mutual Bldgs., West Street, Durban, S.A.

J. C. Matthews, M.R.C.S., L.R.C.P., s.s. *Queen of Bermuda*, c/o Furness Withy Co., Ltd., 56, Leadenhall Street, E.C.3.

J. H. Mayer, M.B., F.R.C.S., The County Hospital, Pembury (Pembury 263), and Woodsgate Country Club, Pembury, Kent (Pembury 242).

I. S. MacLeod, M.B., B.S., 34, Sunderland Road, Forest Hill, S.E.23.

J. O. Laws, M.B., B.Ch., Pathology Dept., Guy's Hospital, S.E.1, and 6, Oakdene Road, Sevenoaks, Kent.

A. T. Moorhouse, M.R.C.S., L.R.C.P., Rotherwood, 24, Avenue Road, Bournemouth.

W. L. Renouf, L.D.S., R.C.S., 69, Halkett Place, St. Helier, Jersey, C.I.

A. W. P. Stone, M.R.C.S., L.R.C.P., The Vineyards, Gt. Baddow, Chelmsford, Essex. (Tel.: Gt. Baddow 241.)

APPOINTMENT

J. K. Baker, M.R.C.O.G., has been appointed Obstetric and Gynæcological Surgeon to the Kent and Canterbury Hospital, Canterbury, and to the Ramsgate General Hospital.

NEW YEAR'S HONOURS

O.B.E. (Civil Division).
J. W. H. Grice, M.R.C.S., L.R.C.P.
P. F. J. L. R. du Vergé, M.C., M.R.C.S., L.R.C.P.

BIRTHS

FRANKL.—On December 21st, 1946, at Cambridge, to Carmen (née Hough), wife of E. K. Frankl—a son.

LYLE.—On January 6th, 1947, at the Woodcote Nursing Home, Beckenham, to Peggy, wife of Gordon Lyle—a daughter (Jane), a sister for Mary.

MARRIAGES

ECKSTEIN—SAWARD.—On December 28th, 1946, Peter Eckstein, M.A., M.B., to Beatrice Saward, B.Sc.

GILLMAN—SHARDLOW.—On December 23rd, 1946, at the Parish Church, Bermondsey, Noel Gillman to Patricia Shardlow. Address, Dale, Wargrave Road, Twyford, Berks.

DEATHS

DALDY.—On December 31st, 1946, at 10, Lansdowne Road, Hove, Arthur Mantell Daldy, M.D., aged 77 years.

EDS. { D.H.F. / H.A.R.

GUY'S HOSPITAL GAZETTE

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PASSIM

THE era of mysterious medicine is over. No longer will the sick be satisfied, let alone cured, by a secret blend of herbs and a few whispered incantations. The scientific public of to-day, who reads in its papers of the latest medical discoveries just as early as the profession sees them in its journals, demands a scientific doctor and is prepared to do without even the frockcoats, silk hats, and broughams which, not so many years ago, marked off their possessors as 'professional men'. The courteous sweep of the silk hat on espying a familiar face has given way to a mere elevation of the eyebrows with or without the raising of a limp flipper to a sombre Homberg.

Nevertheless many of the ways of the profession to-day remain somewhat unaccountable to the laity and still probably invoke in them something of the old wonder. " Waited arf an hour to 'ave a picture of me chest took just cos I got a lump in me neck ! " ; and so on.

In spite of those more erudite patrons of the out-patient department who have delved into the secrets of numberless Home Doctor Encyclopædias which, before the war, could be obtained merely by collecting an adequate number of newspaper coupons, it is still possible to hold a conversation at the bedside without the unfortunate victim understanding too much of what is said. Fortunately the majority of the lay public do not expect to understand medical jargon and are quite content to assume a blissfully indifferent air whilst their prognosis is discussed and metastatic deposits are mapped out on their abdomens.

However one cannot help but appreciate the astonishment (and even disappointment) of the bright young thing who hears that the young physician, in spite of the most painstaking examination of her left chest, has felt " no *thrill* at all." " Well really," she thinks, " that's not quite what I came up for, but of all the nerve . . . ! " Notwithstanding her disillusionment she is ultimately gratified to learn that she is *functional*, and hurries away thinking that the young doctor, queer though he is, is at least a man of the world.

Similarly it cannot be very pleasing for the unlucky patient to hear herself accused of having had one or even more *abortions* during her unfortunate past. A blush steals to her cheeks and she hastily explains once again that what she had was " only a *miscarriage*—honest ! " The synonymy is related to her but of no avail—she just doesn't like the word.

The evil-sounding " cancer " still spells agony and death to the man in the street and quite rightly is banned from use, but the permissible " carcinoma " sounds treacherously similar. Unfortunately the danger of bedside discussion lies in the fact that the particular disease is described so thoroughly and often

at such great length in the sufferer's presence that he can but imagine the worst. Most people are sufficiently educated these days to understand the import of such a word as "malignant" and the phrase "malignant neoplasm," while still possessing a degree of unintelligibility, is a very bare cloak of words and must surely cause an uneasy feeling, if not frank terror, in the heart of many a lay listener. Such reasons make the practice of retiring out of earshot of the patient before discussing certain (if not all) diseases one to be encouraged.

One of our present surgeons at this hospital relates how, a few years ago, he had to suppress the disturbing habit of a surgical ward nurse informing certain of his patients that they were going to be operated on "without an anæsthetic!" Naturally she did not quite mean what most of her audience understood by this ill-explained bulletin and what was intended to be a kind consolation was very wont to produce yet another line on an anxious person's face and make him wonder just what sort of torture lay ahead of him in that little room with the bright lights and where everyone wore a mask to conceal their identity.

A very unfortunate fate which occasionally befalls the out-patient is that of being forgotten. Having been prodded, albeit gently, by what must seem an unending number of enthusiasts, and in spite of the fact that her condition may have aroused such overwhelming interest that she has been almost buried beneath a confusion of stethescopes and made to look like some nightmare telephone exchange, she is left lying on her couch, adorned in a multi-coloured wrap and safely concealed in the customary curtained cubicle. There, overhearing the history of many a complaint and listening longingly to the delightful clink of china as the consultant drinks his tea, the unfortunate awaits chance discovery by anyone who happens to pass that way.

It may, quite wrongly, be considered part of the doctor's privilege to keep his patient waiting but the complete abandonment for a long time of someone whose life is probably just as busy as his, is not only unnecessary but rank bad manners.

The present "appointment" system, while satisfactory in some departments, seems, in others, to fail dismally. The patient who makes an appointment for a certain time, presents himself at that hour, and is ushered into the doctor's esteemed presence some two, three, or even four hours later, can't understand it; he thinks something's gone wrong—and he's right!

THE *Gazette* is very much in need of short articles and so once again we make our customary plea to readers to let us have material. Reports by students, on interesting cases they may have seen, are especially welcome.

READERS will wish to join us in welcoming back Dr. C. S. Darke who has recently returned from military service to take up his civilian duties once more.

WE should like to make clear that although correspondence may be published in the *Gazette* anonymously or under pseudonyms, the writers must inform the Editors of their names as, until these are known, no such letters or articles will be published.

Infantile Eczema

By R. S. ELLIS-BROWN, M.R.C.S., L.R.C.P., M.B., B.S.

SEVERAL cases of infantile eczema have come under my care during the past eight years, and I have had the opportunity of watching some of them grow into childhood. It is hoped that the following observations on the ætiology, course and treatment of the disease may be helpful to other practitioners.

ÆTIOLOGY.

(1) *Allergy* Although the cause of infantile eczema cannot yet be dogmatically stated, most of the cases possess hypersensitivity of the skin. Eczema, asthma, hay-fever and other allergic manifestations occur in other members of the family, and many of the babies who develop eczema also develop asthma at a later period.

Although usually found in bottle-fed infants, it is seen also in those breast-fed. The cause in the latter may be a foreign protein the mother herself is ingesting, but the commonest cause is thought to be sensitization of the skin to lactalbumin, the latter acting as a primary antigen and provoking the formation of secondary antigens. Overfeeding with resulting dyspepsia and constipation or diarrhœa are commonly found. Most of the infants have excellent appetites in spite of this and are greedy feeders, appearing fat and obviously over-fed. Eczema is three times as frequent in male infants as in female, and is commonest during the dentition period—between the fourth month and third year, though often clearing up before it is complete. Occasionally, however, it appears within the first few weeks of life and persists on and off for some years.

Other manifestations of the allergic state are often seen in these patients. The early years of life may run as follows · Soon after birth—within a few weeks—dryness of the skin may be noticed, which is the first evidence of ichthyosis, though the latter will not become marked until two or three years of age. Usually within the first twelve months and occasionally later, eczema develops, the onset often coinciding with weaning on to cow's milk or immediately following vaccination, which appears to sensitive the skin and will also cause the smallest patch of eczema to spread widely. Before proceeding further with the life history, further details on the eczema must be given. Eczema, from whatever cause arising, is a reaction of the skin provoked by sensitization of the cells of the rete mucosum, *i.e.* chiefly an epidermal reaction, the most important feature of which is serous infiltration (œdema) of the epidermis. Urticaria is a dermal reaction, and angio-neurotic œdema a subcutaneous one—both of these are also characterised by œdema of the tissues concerned.

Infantile eczema begins as a small, red, irritable and raised area on one or both cheeks, which rapidly becomes denuded of the horny skin layer and oozes serum, which dries to form crusts. The condition spreads fairly rapidly, other areas appearing and coalescing to involve the whole face, except around the lips, nose and eyelids. The scalp is often affected and in severe cases other parts of the body, namely, the extensor surfaces of the arms and legs. Closely set small vesicles are often seen in the areas and there is a tendency for the eczema to be of dry and scaly or weeping type. The skin appears and feels thickened and œdematous. Vesiculation and weeping may only appear after rubbing and scratching. The trunk becomes involved later, especially in resistant cases. Itching is intense but paroxysmal and often nocturnal, the parts become reddened and œdematous, and the child rubs them vigorously with his limbs or against the pillow while crying. No sleep is obtained by the child or by the mother until towards the morning. This periodicity is also seen in asthma, urticaria, Besnier and other prurigos. Retention of chlorides with great and rapid fluctuations in the water-content of the tissues occurs in eczematous infants, and the periodical exacerbations of the eczema and pruritus is said to correspond to the times at which there is retention of water with accumulation in the skin. Diuresis and loss of weight follow the exacerbation. Carrying this explanation further, the normal equilibrium between the mineral salts in the skin is upset—especially between Calcium salts, which lessen the irritability of muscle and nerve tissue to contact with physical and chemical agents and decrease the permeability of cell-membranes, and Sodium and Potassium salts which increase the latter, making the cell more receptive of water. In eczema there is œdema of the dermal papillæ and rete mucosum (called spongiosis), causing thickening of the inter-papillary processes of the rete mucosum (acanthosis)

and increasing infiltration of the corium by connective tissue proliferation. Keratinisation is imperfect, scales consisting of clumps of nucleated cells (parakeratosis).

This type of eczema is not secondary to any pre-existing infection of the skin, but in the weeping stages septic infection may occur with impetiginous yellow-green crusts forming on the surface, and such infection may involve the skin free of eczema, *e.g.* on the eyelids, nostrils and mouth.

Exposure to hot fires or hot sunlight, cold winds or alkaline soaps aggravate eczema, which is more common in the cold winter months. Overclothing increases the irritation. Digestive upsets, perhaps caused by feeding with an unsuitable milk preparation or by attempts at too rapid a change over from one type of feed to another, aggravate the condition. Diarrhœa, starvation or pyrexia, especially the last, cause improvement, with relapse when condition overcome. The disease shows a great liability to relapse when the skin has become almost normal.

Many of the cases, especially the fat, over-fed majority, clear up completely within a year or eighteen months. At about the age of two years, however, the eczema may change its characters and distribution, especially in the thin type of child, to become Besnier's Prurigo or Flexural Eczema. The face, head, trunk and extensor limb surfaces clear and the dermatitis appears chiefly in the flexures, *e.g.* antecubital and popliteal fossæ, around the mouth and adjacent sides of the face, in the folds of the neck and groins and also on the backs of the hands and both sides of the wrists. Constant rubbing and scratching lead to marked thickening (lichenification), with accentuation of the natural lines of the skin, giving a mosaic appearance, the skin being covered with scales and small blood-crusts. After a paroxysm of itching, which again tends to be nocturnal, redness and excoriation are seen. The edges of such lichenified areas show brownish pigmentation merging gradually into the surrounding skin beyond. The pigmentation is not always confined to these areas and may be generalised, being most marked on the neck, round the eyes and in the flexures. In these cases muscular hypotonia, lack of energy and low blood pressure are seen. Most of the children with this Prurigo are thin, pale, nervous, restless and introspective, and liable to fat dyspepsia if much fat in the diet; but it can be seen in the fat, indolent, hypothyroid child. Characteristically, the skin is ichthyotic and of sallow-grey appearance. Pilo-sebaceous follicles, *e.g.* on the outer thighs, stand out due to contraction of the pilo-motor muscles. Itching may be widespread and is most intense in the antecubital and popliteal fossæ, on the back of wrists and hands and front of ankles, around the mouth, on the forehead especially over the eyebrows, in the folds of the neck, groins and genital organs, and sometimes over the elbows and knees. In mild cases it may be confined to the upper limbs only. Exacerbation of eczematisation with serious oozing, fissuring and perhaps secondary infection occur with paroxysmal itching attacks, but in the intervals of calm simple lichenification with pigmentation is seen. The general appearance of these children indicates hypotonia as revealed by faulty stance, facial pallor and greyish-blue colour of the opposed borders of the lips. The front of the chest is flat, descending in an inclined plane to the lax protuberant abdomen, the area of maximum projection forwards being just below the umbilicus. The thoracic spine is kyphotic, the scapulæ winged, the shoulders rounded and lumbar spine lordosed. Apprehensive and restless, the child is soon exhausted and very sensitive to its surroundings and the influence of persons with whom there is contact. This degree of sensitivity is evident in adult life also. Attacks of itching or asthma, beginning in the evening or at night with fatigue, are often provoked by emotional upsets or by anticipation of an event to be and may cease completely in the quiet communal routine of hospital life, returning under the disturbing influence of relatives and friends at home.

Besnier's Prurigo is due to sensitisation of the skin to antigens, which as in many cases of urticaria, are absorbed from the alimentary tract and escape fixation and destruction in the liver. The reaction is epidermo-dermal, in urticaria it is dermal. In infantile eczema the antigen may be derived from one food-substance, *e.g.* cow's milk albumin, but here many antigens provoke the same reaction. Though derived from proteins, they are non-protein in nature and of simpler composition. Children (and adults) showing allergic signs have a limited power to deal effectively with foreign proteins eaten or injected. The failure of the liver to eliminate rapidly protein derivatives is very important, as the latter circulate in the general blood-stream and react with antibodies in the tissues, *e.g.* the skin, previously sensitised by the first circulating derivatives or antigens. These reactions show themselves as eczema, etc., and are protective in function as they result in the fixation and destruction of the circulating antigens. The skin attempts a vicarious protective function when the liver has failed.

The influence through the nervous system on the body of psychological disturbance is also of great importance. The asthma-eczema-prurigo syndrome is often seen in the only child or the first child, especially if the second does not arrive for several years; the parents adopting an over-anxious attitude towards the child who has inherited his parents' constitution and in turn reflects the same attitude to its surroundings. Marital discord, neurosis of the mother and unhappiness in the home are causal and aggravating factors, which must be remedied for success in treatment.

At about the time that Besnier's prurigo develops or occasionally before or later other allergic manifestations appear, especially asthma, also urticarias and cyclical vomiting. Ordinary urticaria and angioneurotic œdema may occur in quite young children—even babies—from specific food-sensitization, *e.g.* to egg, fish or Brazil nut. Ichthyosis vulgaris is found in a considerable proportion of cases of Besnier's prurigo, and is revealed by the skin showing abnormal dryness and being covered with scales, affecting parts other than the flexures, namely, the extensor surfaces of the limbs, particularly the elbows and knees, and to a less extent the trunk, face, scalp and extremities-areas where the glands are normally least active. The palms and soles show the finer lines obliterated and the deeper ones exaggerated. The nails are dry and brittle, the scalp scaly, the hair thin and dull. Glandular secretion over the affected areas is deficient; ichthyotics cannot perspire enough during exercise or hot weather. The lack of skin fat renders the skin very susceptible to defatting agents, *e.g.* alkaline soaps, washing soda and hard water, so that chapping, fissuring and eczematisation of the hands and wrists are very common. Ichthyosis becomes more marked up to the age of about nine, then improving with puberty, but persisting throughout life. It is associated with allergic manifestations in about fifty per cent., but the family history of allergy is very common. Single cases are met with occasionally. It is an inborn and inherited abnormality, which happens to be often associated with the inherited tendency to allergic diseases. Besnier's prurigo tends to die out at or before puberty—between ten and fifteen—but adult life may be handicapped by attacks of asthma, urticaria, eczema or hay fever.

To complete the allergic picture, attacks of papular urticaria (Prurigo simplex acutus) occur usually between the ages of one and eight years. The irritable rash consists of papules caused by dermal hypersensitivity reactions to antigens absorbed from the alimentary canal, especially when the latter is out of order. It is met with in two distinct types of child—the thin, nervous, active but easily exhausted, emotional child described above, liable to chronic fat dyspepsia and cyclical vomiting—and the fat, water-retention, indolent and occasionally rickety child subject to catarrhal infections of the mucosæ and chronic carbohydrate or fat dyspepsia with diarrhœa, according to which food predominates in the diet. Not infrequently other allergic symptoms precede, coincide with or follow it, but it is often the only manifestation of an allergic state The antigens provoking the attack are only rarely specific or single, *e.g.* eggs. The eruption disappears quickly when the child is admitted to hospital and reappears after returning home. Oxyuriasis is often found and may produce an antigen. Teething may provoke attacks by reflex irritation of the skin or by causing dyspepsia by sleeplessness and restlessness due to pain.

(2) *Local Inflammations.* Four types can be recognised:

(i) *Seborrhoeic type, secondary to Pityriasis Simplex.*

In this, the commonest type, the primary condition is an infection of the infant's scalp with the pityrosporon, caught from the scalp of the mother, which is often found to be scaly with dandruff, and who uses her own hair-brush on the baby's scalp. Discrete, greyish-yellow scaly patches appear first on the scalp around the hair follicles, especially over the anterior fontanelle, which the mother fears to touch. Later the patches become confluent. They cause irritation, so that the infant rubs the scalp and secondary infection with staphylococci occurs. The scaly eruption spreads downwards all round the head, over the ears to the neck, on to the forehead and down the central parts of the face, and to the central parts of the back and chest, as seen in adults. When widespread it also involves the joint flexures of the limbs. The reddened scaly areas resemble seborrhœic dermatitis seen in adolescence and later, but sensitisation of the skin is apt to occur, so that true eczema arises in the rash and spreads over the body. All infants are exposed to pityrosporon infection, but only a few develop the condition Pityriasis Simplex, and in still less numbers of these does it become eczematised. Those who develop Pityriasis Simplex have inherited the seborrhœic constitution and will therefore at puberty or soon after develop seborrhœic dermatitis and acne vulgaris, with pityriasis simplex again. Excess of carbohydrates and fats in the diet act as predisposing factors, as they do in later life with seborrhœic infections.

(ii) *Type provoked by external irritants.*

The latter include friction, pressure, rubbing, scratching, sunlight and strong winds, soap and hard water left to dry on the skin, etc. Local and spreading eczematisation is caused. These infants are very susceptible to skin stimulation, and often show dermographism on the slightest provocation. Infants classified as suffering from Allergic Eczema very often show such skin reactions, and some authorities believe that infantile eczema has most commonly this cause. It is indeed true that the eczematous rash appears on convex, exposed and extensor surfaces.

(iii) *Type secondary to pyogenic skin infections.*

Epidermal sensitisation may occur towards the organisms in a spreading impetigo, perhaps caught from an infected fissure of the mother's nipple, which can also cause pemphigus neonatorum, or perhaps commencing in an infection in a natural skin fold, *e.g.* behind the pinna. The reddened, œdematous and shiny affected area shows vesiculation, with oozing and increased crust formation, and this condition spreads. Sensitisation may also occur to heavy Staphylococcus Aureus infections, *e.g.* in furunculosis, an infected wound, chronic otorrhœa or rhinorrhœa due to sinusitis, scabies with infection, chronic osteomyelitis with overlying skin infection, etc. Eczematous patches appear first around the original lesion and then appear at a distance from it, usually on the extremities. Arising from a single relatively large vesicle on an erythematous base, the inflammation spreads to form a circular patch. The vesicles dry to form yellow crusts, some becoming pustules beforehand.

The above three types occur in older children as well as infants, especially the third type.

(iv) *Type secondary to Napkin Rash.*

Napkin rash consists of an inflamed, eroded and occasionally pyogenically infected, papular and erythematous eruption over the buttocks, external genital organs, lower abdomen and thighs, where the dirty napkin rubs the skin. Eczematous change appears here in rare cases and spreads to other parts of the body. Napkin rash is due to the irritation of ammonia produced by a saprophytic organism in the alkaline fæces of bottle-fed infants. The organism grows in the urine and splits the urea. In addition to Napkin rash, dermatitis may develop secondary to infection of the eroded peri-anal skin with a monilia, usually the Oidium Albicans of Thrush. Circular, raised white patches of Thrush will be seen on the buccal mucosa and tongue. The infection first causes vesicles, pustules and erythematous patches with central scaliness over the area involved by the Napkin rash. The ruptured vesicles and pustules leave raised fringes of horny skin, from which infection spreads to form erythemato-squamous patches with raised edges. Eczematisation commences here and spreads elsewhere. Such infants are usually weak and badly nourished, bottle-fed on cow's milk and suffering from diarrhœa.

(3) *Constitutional Diathesis.*

This cause of infantile eczema is mentioned, though perhaps on less sure foundation than the causes already described. It is supposed that a particular type of child—fat with water-retention, prone to catarrhal infections of the mucosæ, as described under Allergic ætiology above—is liable to develop eczema. This theory pre-supposes the appropriate soil in the inherited and familial exudative diathesis in the catarrhal baby and local irritation of the skin with abrasions by external irritants. The typical picture of infantile eczema, described above as allergic, is indeed seen in the well-nourished, large baby with fine, smooth skin, fair hair and blue eyes. The latter peer out with a clearness and brightness sharpened by contrast with the loathsome frame in which they are set. On the other hand, the thin nervous type of child described above may also develop eczema in infancy and this may be followed by Besnier's Prurigo and Ichthyosis. Both types are prone to attacks of papular urticaria, and are liable to develop asthma also. The above descriptions are of typical cases and types, but occasionally the rules are broken and Prurigo and Ichthyosis are seen in a fat child and eczema in infants of normal build. The thin baby is perhaps more often seen with a dry and scaly eczema, and the fat baby with a more weeping and crusted type; though rubbing will induce exudation in the dry type, and weeping recedes to dryness during the process of healing. The fat child is liable to an outbreak or an aggravation of its eczema when it has reached a climax of maximum retention of water. Such a climax is reached every few weeks—water is lost and retained very easily; the infant's weight varying every several days.

(To be concluded)

A Case of Bilateral Pulmonary Tuberculosis Treated by Artificial Pneumoperitoneum with Phrenic Crush and Contralateral Artfiicial Pneumothorax

By JOHN V. KILBY.

UNTIL recently, bilateral acute exudative Pulmonary Tuberculosis was a disease for which the treatment was total bed rest for a prolonged period. Collapse therapy, though desirable, has been impracticable as the only means available have been Artificial Pneumothorax, Phrenic nerve crush and Thoracoplasty. Artificial Pneumothorax is contraindicated by the grave risk of tuberculous empyema, the possibility of increase in the lesion in the contralateral lung and the fact that once the lung is collapsed in the exudative stage of the disease it is seldom possible to re-aerate it satisfactorily. Phrenic nerve crush alone does not give a good functioning collapse, while Thoracoplasty is a serious and disfiguring operation, with a high mortality in the toxic patient. Artificial Pneumoperitoneum, on the other hand, is a mode of collapse which throws no strain on the patient, does not involve direct contact with the diseased area and by which a satisfactory degree of collapse and immobilisation of the lung may be obtained. Primarily for lower lobe disease, the case described below shows how it may be utilised when the whole lung is acutely involved, giving rise to a relatively rapid transition from the exudative to the productive type of lesion, thus hastening the patient's recovery and enabling further collapse measures to be undertaken for the contralateral upper zone.

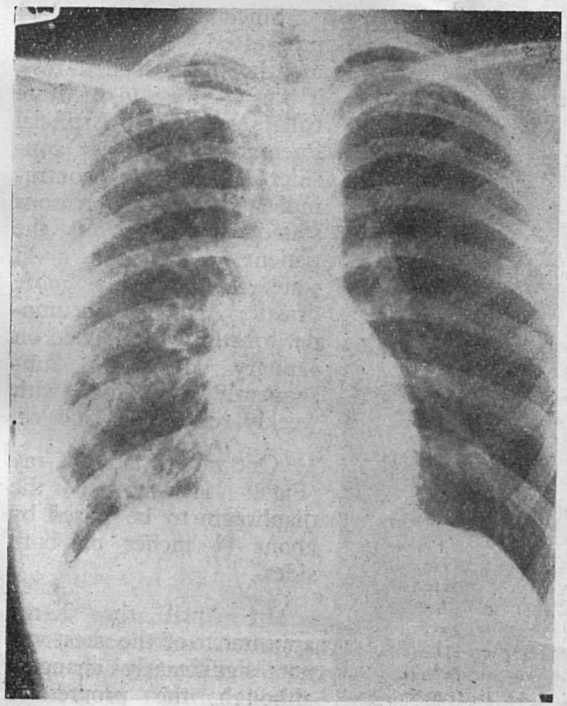


Fig. I.

Case History. — R. R., aged 19 years, joined the Army as a Driver in February, 1944. He remained well until October of that year when he noticed a slightly productive cough. In March, 1945, he observed occasional pleuritic pain. He had already reported sick in February but was refused chest X-ray and was told that

he was worrying too much. In September, he experienced great lassitude and malaise and noticed an increase in the amount of his sputum. Chest X-ray showed :—" Right lung : Diffuse infiltration with softening in all zones. Left lung : Infiltration throughout upper and middle zones, with a cavity one inch in diameter below the clavicle." The sputum was positive.

He was admitted to Preston Hall Sanatorium on November 12th 1945, following one month of complete bed rest at a Military Hospital. On admission he said that he was feeling better after the rest and that the cough was less productive. He had a good appetite.

Examination.—The patient was pale, but not unduly wasted. There was first degree clubbing of the fingers. The only positive findings in the chest were slight muscular wasting of the left side and impairment of the percussion note over the back and front of the left upper chest. There were no adventitious sounds. His weight was 8st. 4½ lbs., his average as far as he knew. The B.S.R. was 20 mm. in one hour (Westergren), and his sputum still positive.

Treatment and Progress.—Complete bed rest was instituted, the disease being acute and widespread.

In January, 1946, his condition remained unchanged. He still had intermittent pyrexia, positive sputum in increased amounts and a B.S.R. of 18 mm. in one hour. X-ray (Fig. I) showed no change in the right side, but an increase of the infiltration of the left upper zone with a cavity below the clavicle.

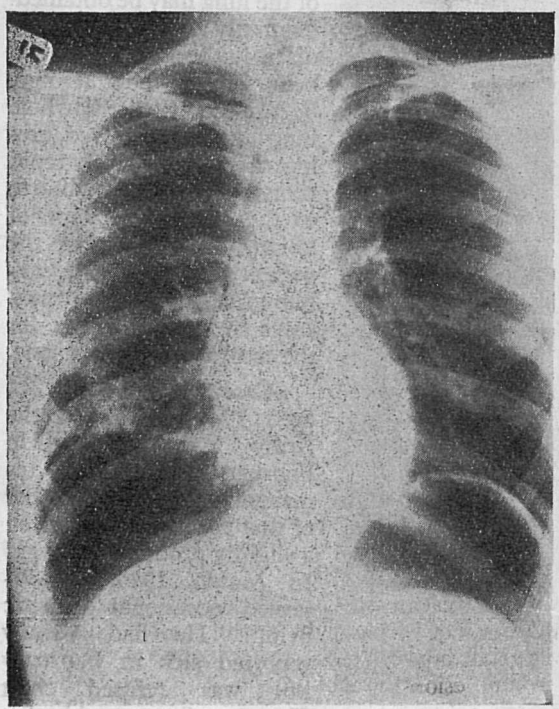


Fig. II.

Since the lesion had progressed despite three months of total bed rest, it was decided to institute collapse therapy. Artificial Pneumothorax was considered to be contra-indicated for the reasons stated above, and as the patient was not in a fit state for anything more drastic, Artificial Pneumoperitoneum was induced on January 11th and subsequently maintained with weekly refills of 1,000 cc.

One month later, X-ray (Fig. II) showed the diaphragm to be raised by about 1½ inches on both sides.

In April the X-ray appearance of the chest was not significantly changed, although the progressive element in the disease had undoubtedly been arrested.

Therefore with a view to the further immobilisation of the lung a Phrenic nerve crush was performed on the right side on May 13th, and by May 23rd X-rays showed the right hemidiaphragm to be raised from the level of the 6th rib to that of the 3rd rib anteriorly. The Vital Capacity was 3,000 cc. and the B.S.R. 15 mm. in one hour.

Between this time and the following August the patient's general condition steadily improved. The B.S.R. fell to 5 mm. in one hour, and the sputum, though still positive, was reduced to a trace. He showed a progressive gain in weight.

In August, X-ray (Fig. III) showed hardening of the shadows in the right lung, though in the left lung the subclavicular cavity was still to be seen on Tomography. It was decided that the left lung could now be collapsed by Artificial Pneumothorax without undue fear of complications, and this was successfully performed on August 21st, though it was of necessity shallow owing to apical adhesions. At Thoracoscopy on October 9th two subapical adhesions were divided. Further adhesions attaching the lung to the mediastinum behind the Subclavian artery had to be left intact.

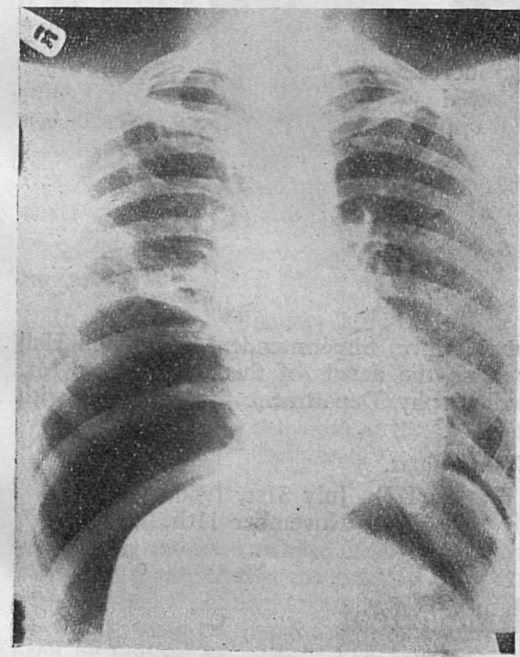


Fig. III.

On November 5th the patient's condition was excellent. His sputum was scanty and negative, the B.S.R. 2 mm. in one hour, and weight 9 st. 7½ lbs. The temperature was normal, and he was allowed up for full toilet. X-ray (Fig. IV) showed a good collapse on the right side, with hard shadows, while the left showed a shallow Artificial Pneumothorax with closure of the cavity, control of the lesion and no pleural fluid.

Conclusions. — A case of bilateral acute exudative pulmonary tuberculosis with cavitation at the left apex has been described in a young man, developing, it would seem, shortly after joining the Army. His condition remained undiagnosed for a year after the onset of symptoms.

The condition continued to spread despite three months of complete bed rest, and collapse therapy was indicated. Other forms of collapse being contraindicated in view of the nature and extent of the lesion, Artificial Pneumoperitoneum was induced, followed by right Phrenic nerve crush after three months. This led to satisfactory collapse and immobilisation of the right lung, allowing healing of the lesion on that side.

A shallow Artificial Pneumothorax was possible on the left side after a further three months, followed by adhesion section.

From the date of the induction of the Artificial Pneumoperitoneum onwards the patient's condition showed a steady improvement and it may be said that this is a case where Artificial Pneumoperitoneum with Phrenic nerve crush arrested the progress of the lesions and considerably hastened the patient's recovery when other forms of collapse therapy were contraindicated.

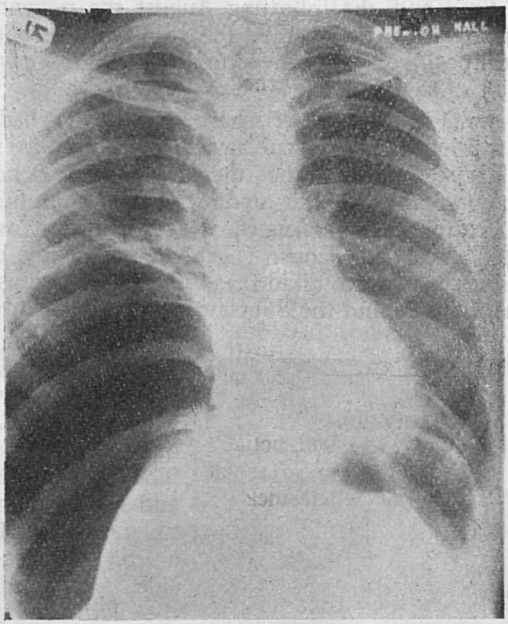


Fig. IV.

I am indebted to Dr. F. Temple Clive, Superintendent of Preston Hall Sanatorium, for permission to publish the details of this case, and to Mr. Twomey, of the Sanatorium Radiography Department for assistance with the photography.

X-ray dates.

(I) January 8th, 1946.
(II) February 12th, 1946.
(III) July 31st, 1946.
(IV) November 11th, 1946.

Whale Meat

By A Village Doctor

As there is talk of whale meat in the air, it is interesting to recall that the first time I tasted it was at a Norwegian Whaling Station, on the fringe of the Antarctic. At the time I was trying to solve some obscure points in connection with the breeding of whales.

Ordinarily the people at the Station lived on very excellent Norwegian preserved provisions. I still cherish memories of " Fiskeballe," or " Stavanger eggs " for short. I had often heard of people eating whale meat, and knew

that the Japs ate a lot of it, but being familiar with the long-range smell of a whaling station, the very thought of it was nauseating.

Baleen whales, *i.e.* " whalebone whales," feed principally on " whale-feed," which consists of small, reddish brown crustaceans exactly like large shrimps, though smaller than prawns, which have a distinctive odour of their own. This is concentrated to the Nth power in the carcase of the whale. Huge patches of whale-feed many hundreds of square yards in area, float about on the surface of the sea according to prevailing winds and tides. This is probably one of the factors concerned in the migration of whales. The whale swims through these patches, using the frayed edges of the baleen plates in the roof of its mouth as a strainer, to separate them from the sea-water.

On the particular day in question, I joined the Norwegians at their mid-day dinner as I had done many times before, and was given what appeared to be a very tempting beefsteak. In surprise, I turned to the Manager and said: " Hello ! where did you get your fresh beef from ? "—a very natural question seeing that we were hundreds of miles from the nearest pasture.

" You like beef ? " he said. " Yoost tell me what you think of *our* beef." It was excellent. A little coarse as to texture, perhaps, but not tough and having a very welcome beefy smell and taste, but no fat. I told him so, and he burst into roars of laughter.

" Tell us the joke," I said, and noticed that all the others were laughing too. Having the smell of a whale carcase at the back of my mind, I had often said that I would hate to eat whale meat.

" You say you wouldn't like to eat whale meat, eh ? Well, dot is yoost what you are eating now ! "

So little did I believe him that I insisted on seeing some meat cut from the carcase and cooked before my eyes. It was whale meat all right.

In *The Times*, of January 20th, the writer of the fourth leading article waxed facetious on the subject of whale meat, which certainly gives ample scope. Should it be put on as a fish course ? Should one speak of fish-cakes or rissoles ? Ought one to use a fish knife ? Even Lee, in his " London Laughs " depicting a whole whale being delivered at the fishmongers, says that somebody is sure to want it filleted. " Delivered " is *le mot juste*, for his picture has a suggestion of parturition about it.

I remember a newly-killed cow-whale which had just been hauled on to the flensing platform, whose ovaries I wanted for investigation. It was lying partly on its side so that the genitalia were exposed. A doctor friend who was with me knew nothing about whales but was intensely interested. He was inspecting what he thought to be the enormous labia and near the middle of each he noticed an ampulla-like opening. " H'm ! " said he. " Bartholin's glands. What an enormous size ! "

You must have noticed how a calf or a lamb when feeding from its mother, butts at the udder now and then. Here was a chance for a bit of fun. " Give it a good kick, as hard as you can, as near to Bartholin's gland as possible," I told him. I knew that the cow was lactating because there was a calf with her when she was killed, only a very short time ago. He did as he was told. To his surprise and discomfiture, out shot a stream of milk which soaked his trousers.

In the whale, the mammary glands are situated on each side of the external genitals, looking like enormous labia. This is a timely reminder that the mammary glands, which in human beings are placed in a more seemly and convenient position, are an integral part of the genital system.

I was going to tell you something about the work we did when investigating the biology of whales ; of the critical examination of their ovaries in an attempt to determine whether they had a regular breeding season ; of their period of gestation, which even yet, is still undetermined ; and especially of their longevity and of the harpoon-head bearing the date 1603 which we found encysted in the blubber of an obviously old whale, whose belly was covered with the stellate scars left by thousands of barnacles down the ages. But all I can think of at the moment is how glad I am I was not compelled to eat any of *her* steaks !

Review

Medicine. By DR. G. LUNTZ. (Ross Careers Books). Robert Ross & Co., Ltd. *Price* 2/6.

THIS little book provides within a small compass detailed information about the medical curriculum and the careers which are available for qualified medical practitioners. It will certainly be of great value to parents with no connections with the medical profession, whose children aspire to become doctors.

Full details are given of the various universities granting medical degrees and also of the examining boards, such as the Conjoint. The author has failed to stress the fact that most mec ical schools will only accept students who are proposing to take a university degree. Nor does he emphasise the fact that at the present time there are many more candidates for entry into the better known schools than can be accepted.

The book is an excellent one for the purposes for which it was written, and it is to be hoped that it may have further editions to keep its information up to date.

J.J.C.

Dental Materia Medica, Pharmacology, and Therapeutics. By WALTER J. DILLING, M.B., Ch.B., and SAMUEL HALLAM, L.D.S., R.C.S.Eng. Third Edition. Cassell. *Price* 13*s.* 6*d.*

THIS popular textbook has now been published in a revised third edition. The authors are to be congratulated on the additions they have made.

Several of the introductory passages to different sections have been re-written and added to with benefit.

There is valuable information on the use of penicillin and the sulphonamide group of drugs in dental surgery. The paragraphs dealing with the implications of the Dangerous Drug Acts have been re-written and help to clarify an Act, which is incomprehensible to the average mind.

This is certainly the best textbook published on the subject in this country.

K.H.

The Conquest of Pain. By GEORGE BANKOFF, M.D., F.R.C.S. Macdonald & Co. *Price* 6*s.*

THIS, the second of the " Conquest Series," tells of the long fight of men to find an anæsthetic, and having found it, the longer fight to prove its worth.

It is certainly justifiable to suggest that every medical and dental student and doctor who will during their lifetime perform countless minor operations and extractions, or administer " gas " for them, should understand the tremendous history that lies behind the anæsthetic. A man did not discover an anæsthetic drug or gas and become a national hero. Most doctors who discovered—or rediscovered—such drugs died as paupers, denounced as " quacks " by the Medical Societies, heretics by the Church, and maniacs by their own friends.

It is a very well written book, and makes one realise that it is not until a later date, that to-day's discoveries are fully appreciated.

C.S.G.M.

Sport

RUGBY

GUY'S *v.* ROYAL AIR FORCE.

(*Played at H.O.P., Wednesday, Jan. 8th.*)

Result: Guy's Nil, Royal Air Force 15.

In preparation for the Inter-Services Championships, the Royal Air Force turned out a strong side against the Hospital and succeeded in winning by one goal, one dropped goal and two tries to nil. Guy's were not at full strength but the side put up a grand performance, and most of the credit was earned by the forwards. None did better than the "A" XV players, D. F. Potter, P. Rademan and A. G. Parks with B. W. Cole always an inspiring leader.

H. Brunow was at stand-off half for the Hospital and his skill enabled the backs to have a fair share of play. Of particular interest was the improved play of F. Van der Westhuizen, but the forwards were inclined to carry their dribbling a little too far when it would have been good policy to have got it back despite the heavy ground.

Lloyd-Davies, the Welsh International, was in magnificent form at full-back for the R.A.F. and he was the big barrier against whom our three-quarters battled in vain. Guy's had a new hooker in J. R. Robinson, a South African from Kimberley, and until he tired towards the finish proved himself an efficient player. D. Le Clus at full-back for Guy's in the absence of T. L. T. Lewis also had a good game, and he was responsible on many occasions in repelling the R.A.F. attacks.

The R.A.F. led at half-time by a goal to nil with a try scored by Cpl. Pollard that F/O Lloyd-Davies converted from under the posts. Guy's had a great chance when F. Le Clus got clean through but his pass to F. Van der Westhuizen was intercepted. Following the interval Guy's had a really good movement between H. Brunow, F. Van der Westhuizen and D. N. H. Owen, and it looked as if the latter had gone over, but the ball had gone loose with P. Rademan and H. Brunow falling on it together. The referee however ordered a drop-out.

Guy's forward rushes looked very dangerous and kept up a constant attack, but F/O Douglas crossed for the R.A.F. in the corner for an unconverted try. The R.A.F. outside-half, F/O Channer, who had played exceedingly well, put the issue beyond doubt when he crossed for a try in the right corner, and later dropped a goal.

The R.A.F. side had an excellent understanding and their forwards never hesitated to use their backs which led to a fine open game with plenty of movement out to the wings.

HOCKEY.

GUY'S *v.* LONDON HOSPITAL.

(Won 6—1)

(*Played at Honor Oak Park, January 15th.*)

There was no score for the first ten minutes although our forwards had most of the ball. The first goal came from Duckworth on the right wing with a fine shot high into the net. From this point to half time we had the game all our own way and Earl, centre forward, and Vans Agnew, playing his first game for Guy's at left inside, scored two goals each.

In the second half, as so frequently happens, we became indolent. We allowed the London to press almost all the time and after a series of near misses their captain eventually scored. Although this was soon neutralised by another goal from Vans Agnew, the last quarter of the game was snappy and neither side scored again.

To criticise is only too easy. We rarely succeed in a fair tackle from the wrong side; the backs stand too square; too many people loiter in the circle in defence, and so on. Nevertheless, the side is still improving steadily and it is to be hoped that this convincing win will prove a happy augury for the future.

Team: F. H. Walker, G. H. Danford, H. Carter; B. Harris, E. A. Murray, R. A. Keable- Elliott, K. Y. Khong, W. Vans Agnew, S. R. Earl, I. Kelsey Fry (Captain), D Duckworth.

GUY'S *v.* HENDON.

(Draw 2—2)

(*Played at Honor Oak Park, January 18th.*)

Owing to the ravages of the influenza epidemic we had but four of our regular team playing and anticipated a troublesome afternoon. As it turned out the game was very even in the first half. Kelsey Fry opened the scoring for Guy's from a good hard centre from Thomas on the left wing. Just before half-time, Hendon broke through and equalised. In the second half, Hendon had more of the ball, although Jenkins scored again for Guy's, against the run of the game. Hendon soon equalised and pressed for the remainder of the time. The defence played well, built round a sound nucleus consisting of Walker in goal, Danford at back and Murray at centre half. Even so, only poor shooting and the final whistle prevented Hendon scoring again.

It was a pleasure to see so many new faces in the first XI and comforting to realise that a team which was no more than a reinforced second XI could hold its own.

GOLF SOCIETY

We are pleased to announce that as a result of a meeting of students held at the end of last term it has been decided to revive the Golf Society.

The meeting was well attended and the following officials were elected :—

President : F. A. Knott, Esq., M.D., M.R.C.P.

Vice-Presidents : A. Bullied, Esq., M.R.C.S., L.R.C.P. L.D.S.,; N. L. Eckhoff, Esq., M.S., F.R.C.S. ; W. Kelsey Fry, M.C., M.R.C.S., L.R.C.P., L.D.S. ; Professor T. B. Johnston, C.B.E., M.D. ; S. H. Wass, Esq., M.S., F.R.C.S. ; J. Whillis, Esq., M.D., M.S.

We are most grateful to the above for accepting these offices and for the keen interest which they have shown in the revival of the Golf Society.

The following officials were also elected :

Hon. Secretary : J. M. D. Grant.

Committee : J. L. Harrington, L.D.S., D. H. Griffith, J. K. Anderson, C. Menzies, W. M. Whamond.

Many competitions and matches, including the annual " Staff *v.* Students," and " Medicals *v.* Dentals " fixtures, are being arranged for the coming season.

By the time this report is published, it is hoped that arrangements will have been concluded for students to play at the Sidcup Golf Club at specially reduced fees. Details will be posted on the Golf Society's notice board in the Colonnade as soon as they are available.

All student members of the Clubs' Union who are interested in golf are warmly welcomed and it is hoped that in the coming season the Golf Society will once again flourish as it did before the war.

J. M. D. G.,
Hon. Sec.

Hospital Information, etc.

NOTICES

SIR ALFRED FRIPP MEMORIAL FELLOWSHIP.

The Sir Alfred Fripp Memorial Fellowship in Child Psychology at Guy's Hospital, open to medical graduates, men or women under the age of 35, preferably with experience in Pædiatrics as well as in Psychological Medicine. Stipend £250 a year. This appointment is for two years and may be held concurrently with a part-time appointment elsewhere. Applications (10 copies) should be forwarded to the Dean, Guy's Hospital Medical School, London Bridge (from whom copies of the regulations may be obtained), together with the names of three referees. Applicants should submit a definite scheme of advanced study or research work to be carried out during the tenure of the Fellowship together with particulars of their previous career. Applications should be forwarded by the 28th February.

DEPARTMENT OF SURGERY

There will be a demonstration in the series of operative procedures on Tuesday, February 4th, at 12 noon.

Mr. R. C. Brock will conduct a departmental round in Job Ward at 10 a.m. on Saturday, February 15th.

H. J. B. ATKINS,
Director of the Surgical Department.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

The next **Examination** for the **Membership** will commence on *Monday, 24th March,* 1947.

Prospective candidates are asked to note that entries accompanied by the certificates and testimonials required by the Bye-Laws must reach the College not later than first post on *Monday, 24th February,* 1947.

Candidates who propose to submit Published Work under the regulations are required to give twenty-eight days' notice, and should apply in writing to the Registrar, without delay, for detailed instructions as to the procedure they should follow. The last day for receiving completed entries for Published Work is also *Monday, 24th February,* 1947.

H. E. A. BOLDERO, D.M.,
Registrar.

Pall Mall East,
London, S.W.1.

CHANGES OF ADDRESS

Charles Baker, O.B.E., M.D., Keat's House, St. Thomas Street, S.E.1. (Tel. : Hop 0151–2) ; and 25, Trinity Square, S.E.1. (Tel. : Hop 0848.)

T. D. Birtwhistle, L.D.S., R.C.S., 179, King's Road, Reading. (Tel. : 2086.)

J. C. Colbeck, M.B., B.S., Director of Pathological and Laboratory Services, County Pathological Laboratory, County Hall, Wakefield, Yorks.

Lance O'Neill Knox, F.R.C.S., 521, Colonial Mutual Bldgs., West St., Durban, S. Africa.

PAPERS BY GUY'S MEN.

Thornton, H. Four molars on each side of the maxilla. *Brit. Dent. J.*, 1947, **82**, 18.

Jackson, W. S. Direct cast post in crown and bridge work. *Ibid.*, 18.

Clayton-Jones, E. Rubella as a cause of congenital deafness in England. *Lancet*, 1947, i, 56.

BIRTHS

HART.—On January 27th, 1947, at Guy's Hospital, to Penelope (née Ellis), wife of R. D. Campbell Hart—a son.

MARRIAGES

DICKSON—PALIN.—On January 11th, 1947, at St. Paul's Church, Wimbledon Park, James Dickson, F/O R.A.F., to Patricia Palin.

DEATHS

JONES.—On December 29th, 1946, Herbert Stanley Jones, M.B., of Bassett Lodge, Southampton.

YOUNG.—On December 20th, 1946, John Young, M.B., B.S., of Hadham Road, Bishops Stortford, aged 81 years.

Eds. { D.H.F. / H.A.R.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LXI. No. 1528 15*th February* 1947 *Ninepence*

PASSIM

IN the six years of war, this country forged for herself a sword of honour such as she had never had before. Never before had so great a proportion of her population taken so indispensable a part in the forging. Never in history was that honour greater. For years she had her back to the wall—the last wall, and for much of the time, as the last defender. She saved Europe by her example.

And she was proud of it. We were all proud of it; proud to have had a hand in that forging and a portion of that honour; proud to have served with men whose moral integrity was such that on no account would they see right wronged. Men in all the forces, men of all the counties, had said again and again, "On no account . . . but over our dead bodies." And so had they behaved themselves. Than that there can be no greater unselfishness, than that no greater self-discipline, no greater morality. What was right had been clear, who had been with them they had known, their duty had lain before them and their duty unflinchingly they did. Having done it they were proud. And was that pride their sole reward? . . . They hadn't thought much about rewards, most of them, but when they had it had been just, "After the war. . . ." The prospect had seemed very heaven.

But after the war, what? Certainly no heaven. The country seems sick—weary perhaps after those six long years. Weary she must be. As she battled, so she had no time to make good the wear and tear. Her body has run into debt. But her spirit? Is there too some sickness of her spirit, some disillusionment, some air of cynicism eating like worm into the old oak? Can a country who so recently proved her moral integrity, who so lately saw clearly, and fulfilled, her duty, become so suddenly spiritually spent? Unlike the body, the soul does not wear thin from exertion. Rather does it grow in stature from pride in accomplishment. If the situation is critical, if the need is great, then surely still will that spirit rise to the occasion. To have been alive with "the few" is to be certain of that. There *is* a great need—a need for greater endeavour, and the situation *is* critical. There is only one way, and there is no short cut. Only by working harder than we have ever worked before, for immediate rewards less than we have ever received before, will we prove that there is no disease in England's soul and will we heal her bodily ailments. As the only hope of cure it is a bitter pill to have to take when for years we felt (if we did not think) that stringency and restriction would end by sudden crisis. But if we see that the emergency is still with us, and the demand that we fulfil our duty still as imperative, then "after the war" may be as bearable as those days in which "that spirit of gallantry and courage made strange heaven out of unbelievable hell." The same unselfishness,

the same self-discipline, the same clear vision and the same comradeship will dispel the disillusionment and cynicism which at present is the country's *mal du coeur*.

Where, might we ask, do we at Guy's fit into this scheme of things? Have we a place? We produce no exports to bring back dollars, no food to give men muscle, no coal to keep men warm. Have we a contribution to make? Indeed we have. We must see to it that by our energies no man lies idle one day longer than he need, no boot comes off the spade for want of health, no hand stays off the loom for want of healing. And those unqualified? By their exertions they must see to it that they ripen with the utmost speed and to the utmost ripeness.

The country is short of doctors. There are many who would fill the jobs but few who can find a way into the limited teaching accommodation. He who fills a place but by idleness makes small use of it must be given short shift and make way for one who will. Let him ask his conscience daily, "which way?" and his conscience will point up a very steep hill. Only if we all climb that steep hill and keep on climbing all the time in the coming years, will this country again be a fit place for our sons and our son's sons and will we be able to say again as was said before :—

"Come the four corners of the world. . . ."

THE Editor has been asked to express Miss MacManus's thanks and appreciation for all the letters she has received. Readers will be interested to read an extract from one of her letters, which appears in this issue.

THE Residents Ball will be held at the Savoy Hotel on Wednesday, 2nd April, 1947. Double Tickets, 3 guineas each (supper included), may be obtained from the President of the Residents, The College, Guy's Hospital. Further announcements will appear in the *Gazette* later.

Chronic Pain in the Right Iliac Fossa

A Clinical Lecture delivered by Mr. S. H. WASS, on July 4th, 1946.

GENTLEMEN,—A clinical lecture is not a method of providing a model answer to an examination question. It is intended to be a discussion upon a clinical problem to enable you to approach that problem in the wards or out-patient department with proper care and clear ideas of its difficulties. In other words the lecture is designed to make you better doctors in the true Guy's sense and to make you think; and because the human brain is only capable of thinking for relatively short periods at a stretch, no clinical lecture should last for more than 45 minutes!

The problem I have chosen to discuss with you to-day is the common symptom of chronic pain in the right iliac fossa. When first we see a patient complaining of this symptom there is a tendency for our thoughts to fly immediately to that much abused diagnosis the "chronic appendix," or for us straightaway to consider the patient neurotic. Either of these assumptions may lead to disastrous consequences and I suggest that the proper approach to this common complaint is to ask ourselves three questions :—

(1) Is there an organic cause for the pain *apart from* the appendix ? ; or

(2) Is the appendix genuinely at fault ? ; or

(3) Is the pain of functional origin ?

I have chosen this order of questioning deliberately because it frequently happens that the appendix is removed when some other organic cause for the pain is present ; and because it too often happens that when no other cause for pain can be found the appendix is removed without good evidence that it is diseased. Functional affections should not be considered until last because there can be no greater error than to stigmatise a patient " neurotic " when in fact organic disease is present. Neurosis should always be a diagnosis made by exclusion.

CAUSES OF PAIN APART FROM THE APPENDIX.

Let us consider first those causes of chronic pain in the right iliac fossa apart from the appendix. In order that nothing of importance shall be omitted, it will be convenient to classify them on an anatomical basis.

First of all the *hernial orifices*. Inguinal and femoral herniæ are most commonly noticed by the patient because of a lump in the groin, but a small hernial swelling may pass unnoticed and the patient come to see you on account of pain. This pain is usually in the groin itself but occasionally is felt in the iliac fossa, so that your examination must always include the hernial orifices.

Pain may also be caused by chronic inflammatory lesions affecting the *inguinal glands* and, because the more proximal external iliac group of glands is often involved at the same time, this type of pain may truly be felt in the iliac fossa. It is unusual, however, for the external iliac glands to be affected without palpable enlargement of the more distal inguinal group ; so that examination should disclose enlarged and tender glands in the groin. A careful search must then be made for a possible focus of infection responsible for the glandular swelling.

Whilst considering glandular swellings we should also bear in mind the *mesenteric glands*, particularly those in the ileo-cæcal angle, which when enlarged are a common cause of pain in the right iliac fossa. Pain arising in these glands is usually due to inflammatory disease, either tuberculous or non-specific. It is wrong to consider every case of mesenteric adenitis to be tuberculous and some people believe there is a very high incidence of non-specific inflammation of these glands. Enlarged mesenteric glands give rise to pain which is felt in the right iliac fossa or around the umbilicus ; the pain is colicky and occurs in definite attacks. The attacks may be acute in onset and simulate acute appendicitis or they may be of a chronic nature. Children are most commonly affected. There is no shifting of the pain as occurs in appendicitis and vomiting is rare ; tenderness and muscular guarding may be present but rigidity is absent. Non-specific mesenteric adenitis frequently follows a sore throat and may be accompanied by low grade fever. A pale, fatty stool, due to blockage of lymphatic vessels (tabes mesenterica) is evidence that the glandular enlargement is tuberculous, and in younger children a positive Mantoux reaction would support such a diagnosis. Some people assert that radiography will assist in diagnosis but I do not believe it to have much value. A straight radiograph can only show the presence of calcified glands and in this state the glands are usually symptomless ; pain arises during the stage of active inflammation before calcification occurs.

Continuing our anatomical classification we pass next to the *cæcum* and *terminal ileum*. There is no doubt that pain in the right iliac fossa can arise in the *cæcum*. It may be due to cæcal distension, when gurgling is present on palpating the cæcum and excessive borborygmi are heard on auscultation of the abdomen. In older patients we must always bear in mind the possibility that cæcal distension may signify chronic intestinal obstruction, due to carcinoma of the pelvic colon, and every effort must be made to exclude such a diagnosis. Simple loading of the cæcum, in association with constipation, may also cause pain in the right iliac fossa. Some people believe that pain may arise from cæcal spasm, a condition analogous to colon spasm and sometimes associated with the passage of mucus per rectum. Organic disease of the cæcum itself seldom causes pain as the first symptom and in cases of carcinoma of the cæcum or actinomycosis careful clinical examination will almost always reveal a palpable lump.

In the *terminal ileum* there are few causes of chronic pain. Crohn's disease, or regional ileitis, may present clinically as an attack of acute or subcute inflammation, closely resembling appendicitis, or more commonly as a case of chronic small-intestinal obstruction. It is a rare disease but should be borne in mind in the differential diagnosis.

Next we must consider conditions in the *urinary tract*. Pyelitis, stone in the ureter or hydronephrosis may all cause pain in the right iliac fossa. Frequency of micturition almost invariably accompanies chronic pyelitis, and pus cells and organisms are present in the urine. Pain from renal or ureteric calculi usually radiates from the loin to the groin, but when a stone become impacted in the ureter the pain may be localised to the iliac fossa; in such cases the previous history of attacks of renal colic is of the utmost importance. Chronic or intermittent hydronephrosis may cause considerable difficulty in diagnosis when the pain is not confined to the loin, because associated urinary symptoms are often entirely absent. In my experience the textbook description of the passage of a large quantity of urine after an attack of hydronephrosis is rare. Careful bimanual palpation of the loin must always be made and in all cases of doubt complete investigation of the urinary tract should be carried out.

Pain in the iliac fossa may also arise from affections of the *spine*. A chronic (tuberculous) psoas abscess will cause pain in the lower quadrant of the abdomen but backache is usually the first symptom. Other diseases and deformities of the spine may cause root pains which are felt in the iliac fossa, but careful analysis of the symptoms should reveal the radiating character of the pain and direct our attention to the spinal column.

The remaining causes of pain in the right iliac fossa, apart from rarities, are those due to diseases of the *female pelvic organs*. I have left this group until last because, although fairly common, I am not competent to discuss the diagnosis of individual gynæcological conditions and because Mr. Blaikley has already lectured to you on this subject. As a generalisation I would say we should not consider the possibility of a gynæcological cause for pain in the iliac fossa unless the attacks of pain bear a definite relationship to the menstrual cycle; or unless there is some disorder of menstruation; or failing that, a swelling in the pelvis is detectable on rectal or vaginal examination. Pain in the iliac fossa together with a vaginal discharge certainly does not justify a diagnosis of salpingitis.

We have now considered a formidable list of causes of pain in the right iliac fossa but they should all be given careful consideration when we see a patient complaining of this symptom. Our investigation must include a detailed and accurate history; careful palpation of the abdomen, the hernial orifices and the glands of the groin; the performance of rectal and pelvic examinations; examination of the spine and testing of the urine.

THE "CHRONIC APPENDIX."

Having by these methods eliminated, to the best of our ability, the presence of organic disease in other organs, we now turn our attention to the appendix itself, asking the second question "Can the appendix genuinely be held responsible for this patient's pain?" The term "chronic appendicitis" is misleading. It is a term which is loosely used, often without any consideration of its meaning. Some people believe that chronic appendicitis is a clinical entity of fairly frequent occurrence, others that there is no such disease. Sir Heneage Ogilvie used to teach that a good surgeon, up to the age of 30, would refuse to believe in the existence of chronic appendicitis; between 30 and 40 he would wonder if it occurred but never accept a fee for removing the appendix; and over the age of 40 he would be convinced that it was a clinical entity. I think it is important for us to consider carefully what we mean by "chronic appendicitis" and to this end we must study the pathological conditions which affect the appendix and the clinical syndromes to which they might give rise.

Apart from acute appendicitis, which we are not discussing to-day, two definite clinical syndromes can be recognised—recurrent subacute appendicitis and recurrent appendicular colic. By *recurrent subacute appendicitis* we mean recurring attacks of mild inflammation. In the earlier of these attacks pain begins in the epigastric or umbilical regions and settles down in the right iliac fossa; in later attacks this shifting character is often absent and the pain is felt in the iliac fossa from the start. Fever is slight or absent but the tongue is furred and there is loss of appetite. Vomiting is unusual. Examination of the abdomen during the attack will show tenderness and guarding, but no rigidity, in the right iliac fossa; or alternatively there will be tenderness on rectal examination. The attacks usually last 24 or 48 hours and then subside. In *recurrent appendicular colic* the pain is usually more severe and is spasmodic in character. It is felt in the umbilical region but abdominal palpation will show tenderness and guarding over the appendix. Vomiting may occur, but the tongue is clean, there is no loss of appetite and fever is absent. The bouts of colic may persist for one or two days. With both appendicular colic and recurrent subacute appendicitis most patients have periods of complete freedom from symptoms, lasting several months, between the attacks of pain. If we are able to examine the patient during an attack it is usually possible to distinguish between the two clinical syndromes just described. In the intervals no abnormal physical signs may be present and we then depend for diagnosis upon an accurate history, together with any observations the doctor may have recorded during previous attacks. I do not place much value upon radiography as an aid to diagnosis. Failure of the appendix to be visualised in the barium follow-through examination does not signify that it is pathological; 60 per cent. of appendices lie behind the cæcum and when this organ is filled with barium the retrocæcal appendix obviously cannot be seen. Irregular filling of the appendix, kinking, or apparent fixity during the screening

examination are not definite signs of disease. In patients who show persistent tenderness in the right iliac fossa it is occasionally possible to demonstrate that the point of tenderness corresponds with the position of the barium-filled appendix; such evidence may be of value in doubtful cases.

When a diagnosis of recurrent subacute appendicitis or recurrent appendicular colic has been made appendicectomy should be advised. These conditions constitute two types of "chronic appendix" inasmuch as the appendix is repeatedly giving rise to trouble, but neither of them can truly be called "chronic appendicitis," which term should signify persistent chronic inflammation of the appendix. It sometimes happens, however, after repeated attacks of mild inflammation or colic, that some pain and tenderness persist even in the intervals of relative freedom. If the term "chronic appendicitis" is ever justifiable I believe it can be applied to this type of case, but I do not believe that chronic inflammation of the appendix ever arises *de novo* without a preceding history of recurring attacks of pain.

To summarise the position with regard to the "chronic appendix," I recognise three conditions for which I advise appendicectomy—recurrent subacute appendicitis, recurrent appendicular colic and "chronic appendicitis" occurring as a sequel to either of the former conditions. I do not recognise chronic appendicitis, as a cause of persistent pain in the right iliac fossa, in the absence of a history of definite *attacks* of pain in the past.

FUNCTIONAL PAIN.

The last group of patients with which we have to deal comprises those in whom we can find no evidence of disease apart from the appendix and in whom we are not convinced by the history that the appendix itself can be considered genuinely at fault. In such cases the history is commonly one of persistent chronic pain in the right iliac fossa, without intervals of freedom and without definite *attacks* of pain in the past; alternatively, if the patient does complain of "attacks" of pain, these attacks are usually of greater frequency and shorter duration than we should expect from organic causes. Although mistakes can be made the majority of such patients are suffering from pain of functional origin and they present problems both in diagnosis and treatment.

You must not expect the patient to volunteer the information that the pain is imaginary. Some people are true malingerers but most of them think they have got a perfectly genuine pain. It often requires great patience and considerable tact to obtain evidence in support of your hypothesis of fuctional disease. Nevertheless if you treat your patients sympathetically and ask only indirect questions it is surprising how often you discover a psychological basis for their symptoms.

The management of these patients is extremely difficult, but if you are prepared to spend time on them your efforts will often be rewarded. Some people are quickly reassured when you convince them that complete examination has not disclosed any evidence of organic disease, and they are then willing to accept a minor pain as something of no serious significance and to try to dismiss it from their minds. Others are not so easily assured and not so ready to accept your judgment; they want to know why they have the pain and that is a question which I, at any rate, cannot answer. Mr. Blaikley told me of his method of dealing with this type of patient and I have found it most useful.

The patient is told that the pain is of nervous origin and due to worry, anxiety, overwork or other psychological troubles; and whereas some people in these circumstances get headaches or backaches that particular individual has his "weak spot" in the right iliac fossa and feels his unpleasant symptoms in that situation. A simple explanation on these lines will often produce a contented patient; the explanation may not be very scientific but practically it is effective. There remains, however, a group of patients who are not satisfied with any explanation or reassurance and these you must refer to an expert psychologist.

At all costs you must avoid appendicectomy in the neurotic patient. I appreciate that the difficulties of the general practitioner in such cases are much greater than those of the consultant. The consultant sees the patient on one occasion only and as a last resource can always dismiss him with the promise of writing the details to his doctor. The practitioner cannot dismiss his patient so easily and is haunted by him for months or years. When you cannot reassure the patient it is most important you should not advise appendicectomy in order to satisfy his whim or to get rid of him from your surgery. If you send a patient to a consultant do not send him with the idea that his appendix is going to be removed and then consider yourself "let down" if the consultant will not operate: tell the patient you are requesting a second opinion on the case, and be prepared to accept advice against removal of the appendix. It is better to lose a truculent patient altogether than have him return with the same pain after the appendix has been removed on your advice. It is better also to lose such a patient than to feel yourself responsible for that dreadful sequence of events in which an ill-advised appendicectomy is followed by operations for adhesions or removal of other organs, leading finally to the creation of a confirmed hypochondriac.

Infantile Eczema—II

By R. S. ELLIS-BROWN, M.R.C.S., L.R.C.P., M.B., B.S.

(concluded)

Treatment.

(1) *Of Allergic Eczema.*

General treatment. It is necessary to eliminate from the diet as much as possible the exciting protein—usually lactalbumin. The entire omission of milk under the age of six months is difficult on account of its high phosphorus and calcium content. Synthetic products approaching milk in composition are often partially refused by the infant because of the different taste and lessened digestibility If the infant is under six months old and is breast fed, first ensure that the mother's diet is not only adequate in calcium and vitamins, but is also well balanced. Prescribe additional calcium, *e.g.* Calcii Gluconas gr. 60 t.d.s. or Tab. Calcii Lactatis gr. 10 t.d.s., and vitamins A, C and D, *e.g.* Cod or Halibut liver oil preparation and Ascorbic Acid mg. 50–100 daily. It is then necessary to diminish the amount of breast milk taken at each feed by permitting the infant to suckle for about five minutes only at each breast. This diminished time will reduce breast stimulation and in a few days, wherein any painful accumulations of milk can be withdrawn and discarded, the amount of milk produced will be less. The mother's fluid intake must be restricted moderately also. These babies are often over-fed and will thus benefit from this procedure and gain in weight at a more normal rate, *e.g.* four or six ounces per week If, however, it becomes apparent after three or four days that insufficient nourishment is being taken, small complementary feeds of one to three fluid ounces must be given after some of the breast feeds. Preparations free of lactalbumin must be given as described later. If no improvement follows it will be necessary to wean the baby completely from the breast on to a suitable "milk" preparation free of lactalbumin In this event, give the infant calcium in the form of Syrupus Calcii Lactophosphatis

m 30 t.d.s. ex. aq. and vitamins in the form of a fish liver oil and orange juice. Both the fat and the thin baby also benefit from the administration of thyroid, *e.g.* the dry extract gr. $\frac{1}{8}$–$\frac{1}{4}$ as one dose daily. The change to a solid and mixed, but milk free, dietary will have to be made as soon as possible at about the age of six months, when the infant's alimentary system has developed sufficiently to digest other foods.

If the infant is over six months old when first developing eczema and is breast-fed, it is necessary to wean on to a suitable "milk" preparation first, and then to change over during the succeeding few weeks to a solid, milk-free diet. It is important to guard against over-feeding with fats and carbohydrates, to avoid dyspepsia with diarrhœa and sudden excessive gains in weight, *e.g.* half a pound or more per week.

If the infant is bottle-fed at the time of developing eczema, cow's milk or preparations thereof, unless prepared as described below, must be discontinued, and the infant given a suitable preparation until old enough to take a semi-solid diet.

The following are suitable lactalbumin-free preparations for the infant:

(i) Almata proprietary food (Reckitt & Colman, Ltd.), containing Protein 12.5 per cent., fat 27 per cent., and carbohydrate 54.6 per cent. It is composed of eggs, butter-fat, dextrimaltose and fruit-juice with some casein. At present it is only obtainable in small amounts from the manufacturers, but it was used extensively before the war.

(ii) Allergilac (Cow & Gate) is a dried milk with most of the lactalbumin removed. Formerly these infants were believed to have a—or hypo—chlorhydria; but subsequent work by Oriel and Barber has shown normal acid content of gastric juice commonly present in these infants. However, this preparation is acidified with lactic acid to reduce its buffering power, and it is composed of protein 25.8 per cent. (only 1 per cent. of this is lactalbumin, the remainder being casein denaturised in the preparation of Allergilac by heat), fat 18 per cent., carbohydrate (lactose) 43.5 per cent., and lactic acid 2.7 per cent.

(iii) Lactic acid milk preparation. Cow's milk owing to its high protein content (chiefly in the form of calcium caseinate) has a very high buffer value compared with breast milk, and absorbs much of the infant's gastric hydrochloric acid. The addition of lactic or hydrochloric acid satisfies the buffer substances and leaves all the infant's acid free for peptic digestion. One pint of cow's milk is boiled for five minutes, then when cooler the skin is thoroughly removed from the surface. This contains the lactalbumin. Lactic acid B.P., 45 drops, is then added to the cool milk slowly drop by drop, stirring well (these precautions avoid a tendency to curdling). An alternative method is to add two drops of acid to each fluid ounce of milk in the baby's bottle just before the feed, shaking well after the addition of each drop. A fine flocculent curd forms and no further clotting occurs after ingestion. Hydrochloric acid milk is prepared in the same way. Cow's milk is boiled for five minutes, then when cooler the skin is thoroughly removed from the surface. This contains the coagulable lactalbumin. Then, when further cooled, $1\frac{1}{2}$ drops of Acid. Hydrochloric Dil. B.P. are added to each fluid ounce of milk, just before feeding the baby. The preparation cannot be heated again or curdling will result. Water and sugar can be added as required.

The diet for the infant from six to nine months old would be as follows, presuming the weight to be fifteen to eighteen pounds:

7 a.m.—Hydrochloric acid milk preparation .... 4–5 fl. oz.
Water .... 2 ,, ,,
Sugar, preferably glucose .... 1 heaped teaspoonful.
In place of this mixture Allergilac as a 7 fl. oz. feed may be given.

10.15 a.m.—Above preparation to which is added, previously prepared and cooked, 1–3 heaped teaspoonfuls of a cereal such as Sister Laura's Food, Robinson's Patent Groats, or Patent Barley or Farex. The yolk of a lightly boiled egg is introduced with this feed and the amount is increased gradually from a half to two teaspoonsful.

2 p.m.—Hydrochloric acid milk preparation or other suitable preparation .... 4–5 fl. oz.
Sugar .... 1 heaped teaspoonful.
Also 1 fl. oz. given of a broth prepared from veal or beef bones, with calf or ox liver and leaf and root vegetables.

6 p.m.—As at 10.15 a.m., using a different cereal and omitting the yolk of egg.

10 p.m.—As at 7 a.m.

Orange juice or tomato juice, 2–3 teaspoonfuls, diluted and sweetened are also given daily between two feeds. A cod or halibut liver oil preparation is also given, except in hot weather, as one or more drops as tolerated, before three feeds daily.

Over the age of nine months other foods are gradually introduced and the whole increased in amount, *e.g.* rusks, sweet and plain biscuits, toast, bacon fat, beef dripping, mashed potatoes, sieved vegetables, chicken, sole, plaice, rice, junket, thin bread, stewed fruit, Irish stew, liver, plain cheese and whole-meal bread. It is wise to keep the fluid (and salt) intake of the fat type of child restricted a little below 2 fl. oz. per pound body weight per day. As the age advances over nine months, these children do well on a diet relatively rich in protein, thus freshly cooked meat, fish, chicken, liver, kidneys, sweetbreads and brains are introduced. The foods to be avoided in the fat child at this age are porridge, cane sugar, jams, sweets, pastries, puddings, cakes, pork, bacon and egg white.

It is essential to prevent the infant from scratching, thus limbs must be splinted with cardboard and kept away from the body. Finger nails must be kept short. Chloral hydrate and bromide gr. 2 of each per year of age, in syrup of orange and water can be given four hourly for restlessness. The body should not be allowed to become very warm—cotton in summer and silk or linen in winter should be worn next to the skin, in place of woollen garments. The baby can be bathed in water or preferably isotonic saline (one 640-grain packet of salt to a gallon of water), at just below body-heat, *i.e.* 95 F.; but in place of soap, toilet oatmeal in a muslin bag is to be placed in the bath, and the skin will be left very dry afterwards. Particular attention must be paid to drying in all flexures and on the scalp.

Resistant cases are occasionally seen, which in spite of the above methods of treatment continue to alternate between activity and quiescence, until between the ages of one and two years the condition gradually disappears.

To complete this section I will indicate the principles of treatment of Besnier's Prurigo, Ichthyosis and Papular Urticaria. Children suffering from the eczema-prurigo-asthma syndrome are hypersensitive to so many different allergens and physical and psychological stimuli that it is useless to attempt desensitisation. Treatment should aim at stabilizing the nervous system and rendering it less liable to violent reactions to stimuli. Great benefit is derived from living as completely as possible in the open air, where cool air and sunshine stimulate the skin and body, and exert a soothing psychological influence, especially where the climate is bracing, *e.g.* by the sea, or on high ground. Allergic manifestations cease under such conditions—asthma disappears, skin irritation and eczema almost go and ichthyosis improves greatly, further vaso-motor and muscle tone improve and the child's stance becomes erect. Relapse follows the return of the child to the town, especially if the home is not a happy and contented one. Attempts to correct the latter should be made, and continued stimulation of the skin advised, *e.g.* by hot and cold douches, ultra-violet light baths, light clothing and open-air exercise. Skin irritation should be overcome by local applications to be described and two fluid ounces of Liquor Picis Carbonis added to each bath. The diet should continue to be rich in protein; the thin child encouraged to take crisp, dry carbohydrate foods; and the fat child restricted in carbohydrates, especially soft starchy foods. These allergic children tend to become sensitive to other foods after being placed on a mixed semi-solid diet in later infancy, and milk can then often be well tolerated. Thus certain foods may have to be excluded, and if doubt is experienced in their identification, scratch or intradermal tests can be performed, using active protein solutions, *e.g.* of egg white or yolk, of various fishes, milk, cheese, etc. (C. L. Bencard, Ltd.). Dry extract of thyroid gland gr. ¼–1 given as a single dose daily is valuable, avoiding over-dosage as evidenced by tachycardia, sweating, diarrhœa, undue loss of weight, increased nervousness or palpitation. Sleeplessness can be overcome by giving Sodium Bromide gr. 4–10 or Tab. Phenobarbitonum gr. ½ o.n. If papular urticaria be troublesome give small doses of Hydrargyrum Subchloridum (gr. ⅛ or ¼) or Hydrargyrum cum Creta (grey powder) (gr. 1–4) occasionally at bedtime, followed by a small saline aperient next morning. Periodically, give an alkaline stomachic mixture for several days, *e.g.* Mistura Quassiæ cum Rheo pro Infantibus N.W.F. dr. 1–4 t.d.s.a.c. A good effect is occasionally noted if calcium be given, *e.g.* Syrupus Calcii Lactophosphatis dr. 1–2 t.d.s.p.c.

Local Treatment. In the early acute stage lotions should be used. When weeping is slight, the skin showing erythema and vesiculation, Lotio Calaminæ G.H.P. applied frequently is very valuable as it dries to form a protective splinting of the surface.

If weeping is prominent, add Liquor Plumbi Subacetatis dilutum dr. 1–2 to each fl. oz. of Lotio Calaminæ, and apply soaked into thin plain lint, keeping the latter moist and using the minimum of bandage. This lotion in addition to cooling forms a protective layer of insoluble lead albuminate. Pure Liquor Plumbi Subacetatis Dilutum (Lotio Plumbi G.H.P.) may also be applied similarly. Oiled silk must not be used as an outer dressing because it keeps the parts too warm. After a few days, when the initial acute reaction has commenced to subside, Coal Tar pastes exert a very beneficial action. The following formulæ may be used :—Crude Coal Tar 3 per cent. in Zinc Paste B.P., or Prepared Coal Tar 7 per cent. (made by heating Crude Coal Tar) as White's Tar Paste :—

R

Picis Carbonis Præparatæ dr. ss
Pulvis Zinci Oxidi dr. 1 } misce
Pulvis Amyli dr. 3 } misce,
Paraffini Molle dr. 3 } misce

or for milder cases, Ethereal Solution of Coal Tar 3 per cent. as Pasta Picis Ætheriæ, G.H.P. The paste chosen is applied thickly smeared on lint or butter muslin, and for the face a mask is prepared with holes cut for the mouth, nose and eyes. Applications are repeated twice daily if there is some weeping, but later less frequently. Scales can be wiped away using olive oil and warm saline baths, but areas of thick crusts and scabs will require starch poultices. A cooling starch solution, prepared with boiling water, is spread on lint and covered with a single layer of gauze. This is applied with the gauze next to the scabs, and cotton wool and bandage are applied. The eyes, lips and nose are cleansed with warm Sodium Bicarbonate lotion, one heaped teaspoonful to the pint. Occasionally in neglected cases secondary infection has occurred and it is then necessary to add an antiseptic to the saline bath, *e.g.* one packet containing fifteen grains of Potassium Permanganate added to a gallon of water to make a 1 in 4,000 solution. Hydrargyrum Perchloridum may be used in place of Permanganate, but greater care must be taken to ensure that none is drunk by the baby. Coal Tar pastes must not be used until such sepsis has disappeared.

All the above therapy is gradually discontinued as improvement results in a cure. Exacerbations will necessitate renewed efforts. Besnier's Prurigo will require the continued application of one of the Coal Tar pastes, but such treatment is palliative only and efforts should be concentrated on general treatment. Chronic patches of eczema and lichenified areas of Prurigo can however be stimulated to heal by painting with Crude Coal Tar pure or diluted with Collodium Acetonum B.P.C., applied daily for a few days, followed by Zinc Paste.

(2) *Of Eczema due to Local inflammation.*

(i) *Type secondary to Pityriasis Simplex.*

This condition is very amenable to treatment. It is first necessary to overcome and eliminate the Pityrosporon infection of the scalp and adjacent skin. These parts are washed daily, especially if scaliness is severe, for a few days with Spiritus Saponatus B.P.C. (soft soap in alcohol) in warm water. Further scales are removed by rubbing gently with olive oil. After this initial treatment the following ointment is applied daily :—

R

Acidi Salicylici gr. 15
Sulphuris Sublimati gr. 15
Paraffini Molle ad oz. 1

Soft soap shampoos are also given daily followed by the application of more ointment. The scalp and skin of the face and neck are soon rendered normal again by these procedures. If the limb flexures are involved in the infection, the ointment should be applied on these parts ; but if there is eczematisation here also, initial cooling lotions should be applied followed by a Coal Tar paste. General isotonic saline baths are given daily. Usually the elimination of the infection quickly causes eczematisation to subside and ordinary water baths can be resumed, using soft or super-fatted soap. However, if eczematisation is severe in the early acute stage, cooling lotions can be applied as in the case of allergic eczema, before commencing the above treatment. Hair brushes and combs must be regularly washed.

(ii) *Type secondary to physical irritants.*

Immediate elimination of the cause is followed by the application of cooling lotions as described. Contact of the parts with soap and water is avoided ; olive oil can be used for their cleansing. As the condition subsides Pasta Zinci Oxidi cum Acido

Salicylico B.P.C. is applied or Pasta Zinci Oxidi Composita B.P. (Zinc Paste) containing 1 per cent. Hydrargyrum Ammoniatum. If progression to normal appears delayed, stimulant antiseptics should be added to either paste, *e.g.* 7 per cent. Liquor Picis Carbonis or 1–2 per cent. Picis Carbonis Præparata or Ichthyol.

(iii) *Type secondary to pyogenic skin infections.*

The cause of this must first be treated, *e.g.* an infected, cracked maternal nipple must receive Cremor Sulphanilamidi et Sulphathiazoli N.W.F. or similar preparation, reapplied after every breast-feed ; scabies must be eliminated ; middle ear and sinus infections may require surgery or a course of suitable sulphonamide according to the organism responsible. By overcoming the cause further spread of eczema ceases and the rash subsides, aided as described under Type (ii) above. A further word is necessary with regard to impetigo, because infection of the eczematised areas is apt to occur easily, considerably aggravating the condition, especially if extensive over the body. Saline baths using toilet oatmeal are necessary, and large crusts are removed by starch poultices and olive oil. Cremor Penicillin or Lotio Cupro-Zincica N.W.F. is applied warmed three times daily to the infected areas. It is important to confine the lotion to the impetiginised areas, because it causes acutely eczematised areas to irritate temporarily. Impetiginised areas consist of breaking, cloudy vesicles on erythematous bases, which dry to form characteristic yellow or brownish-yellow crusts, adherent to the skin beneath. The latter is raw, and oozes and bleeds when the crusts are lifted. When the lotion is dry, dust lightly over the body powdered sulphanilamide. The eyes, nose and lips are bathed many times daily at first with warm Sodium Bicarbonate lotion. Overcoming the infection in this way leads to healing of the whole surface of the body except some of the flexures, *e.g.* behind the ears, in the inguinal region and in the creases of the palms and soles. For these regions Penicillin Cream or Zinc Paste is a good application if thoroughly applied after cleansing the parts from scales and crusts. Fresh lesions can be produced by scratching, thus this must be prevented.

(iv) *Type secondary to Napkin Rash.*

In these cases as in the previous type, neglect or inadequate treatment of the primary rash leads to eczematisation. Treatment must again be directed at first to the initial cause. Frequent changing of wet napkins is essential, and after washing, they should be rinsed in 1 in 4,000 Hydrargyrum Perchloridum in water (one 7½-grain tablet dissolved in two quarts of water) or a saturated solution of boric acid, then wrung out and dried. It is advisable to change the alkaline reaction of the stools and render them slightly acid. This is effected by increasing the carbohydrates in the diet moderately. An initial dose of Hydrargyrum cum Creta gr. 1 per year of life is given. Pasta Zinci Oxidi cum Acido Salicylico (Lassar's Paste) containing 1 per cent. Hydrargyrum Ammoniatum should be freely applied daily and after defæcation to the area of the napkin rash after the morning saline bath. Eczematised areas can be treated as under Type (ii) if necessary. If monilia infection is present, this should receive the following treatment. The general health is often poor and must be improved by ensuring an adequate diet. Instruction in strict cleanliness of teats, bottles, napkins, etc., must be given. After every feed one of the following antiseptic lotions should be applied to the buccal mucosa :—

Glycerinum Boracis B.P. or R.
Potassii Chloratis gr. 10
Glycerini dr. 1
Aquam ad fl. oz. 1,

or R

Sodii Sulphitis dr. 1
Glycerini m. 10
Aquam Dest. ad fl. oz. 1.

Also the fungus can be gently scraped away with gauze from inside the mouth and will not reappear on the same site. Another application of great value is 1 per cent. aqueous solution of Gentian Violet applied twice daily. To the infected areas on the buttock region the most effective application is 1 per cent. Gentian Violet in a Zinc Cream (Zinc oxide and Lanoline, dr. 2 aa, with Olive oil and Calcium water aa to oz. 1).

I am greatly indebted to Dr. H. W. Barber for examining this paper and giving his criticism and advice.

REFERENCES.

Section of Dermatology. *Taylor's Practice of Medicine.* Also references in above book on page 983, numbers 9, 42, 45, 46, 47, 48, 51 and 54.

Correspondence

SIR,—I enclose herewith an extract from an interesting letter which I have just received from Miss MacManus. I hope you may be able to find room for it in the *Gazette* of February 14th.

I am, etc.,

Guy's Hospital, S.E.1. T. B. JOHNSTON.

Bequai Island,
The Grenadines,
Windward Islands,
British West Indies.
January 5th, 1947.

DEAR PROFESSOR JOHNSTON,

The warm-hearted cable from all the Guy's "family" congratulating me on the C.B.E. gave me much pleasure. Quite apart from the occasion—which is very nice—I haven't had any letters for nearly a month and it *was* good to feel Guy's stretching out its hand to me.

This is a queer little island, about 6 miles by 3 I think, though no one can tell me for certain. Miss Shenton (old St. Thomas'), who is my Public Health expert colleague, and I sailed over here this morning from St. Vincent, where we had been staying in comfort for three days in Government House. We alternate between luxury and extreme simplicity, such as farm houses or Police Stations on lonely coasts—all good fun. We are on our way to Grenada which island shares with St. Vincent this big straggling group, the Grenadines. *This* island has 4,000 inhabitants, two Nurse-Midwives, a Dispenser (who in these islands is a Doctor's Assistant and does all sorts of Senior Dresser jobs), a Sanitary Inspector who does valiant work in the towns and villages re garbage, pit latrines, static water, chasing the anopheles, housing, overcrowding, and a lot of other valuable activities. They are all coloured, some locally trained in a larger island, some have been away for special courses in more advanced places like Trinidad or Jamica.

Many of them are really good, and with the acute shortage of doctors in the B.W.I. all these assistants carry a lot of responsibility.

The training of nurses is very far from reaching our General Nursing Council standard. Some of the islands have got a State Registration Act on their Statute books, but they cannot carry it out properly until they get more good European Matrons and Sister Tutors or Sisters with teaching experience to organise the Nurses' training, and to stick to what they have got passed and laid down. There is interesting work here for Doctors and Sisters-in-charge, of the right character and temperament. Posts are not well paid but most legislatures are trying to improve this, and if one is fond of an outdoor life and doesn't mind roughing it when touring the "back areas" it can be a very pleasant life.

Miss Shenton and I went to the Races in St. Vincent on New Year's Day—a terrific holiday for the island. Little boys in groups beating home-made sheep and goat skin drums of different sizes and occasionally accompanied by some squeaker or flute, made rhythmic noises from 5 a.m., parading the hilly paths and roads.

We did a busy morning's work getting the hang of the Hospital's organisation—a poor one—and then raced back to our boarding house, changed, swallowed a mouthful of food and were picked up and taken to the races—our first outing of that sort—by a nice young man of H.S. rank from Belfast, who was sent out recently by the Colonial Office and found on arrival that he was expected to be the full Surgeon for 100 beds. One of the local Surgeons was running a horse in the races, and two other medicals, one from Grenada, had sent horses over in the local schooner—so we had a cheery day, and I lost steadily and enjoyed myself.

The S.M.O. in St. Vincent is an old Guy's man, now retired from Africa, but doing a job here for a few years to help out. He is very keen and go-ahead about Public Health, Dispensaries and Clinics throughout the island.

We flew to Dominica in an amphibian. It has no airfield, so most people try to choke you off. We were lucky to get a chance of going over with the circuit judge. It is a lovely island, famous for the finest citrus fruits, *but* very few roads. No regular

steamer calls now—the old island coastal boat was sunk during the war, so the planters are hard up and acres of first-class fruit drop and rot for lack of transport. We did a three day pony trip on mountain paths on the wild windward coast, visiting villages and the Carib reserve—not very pure bred now—and meeting Nurse-Midwives, young and ancient with equipment to match, and Sanitary Inspectors, all the way along. It is rather unsettled, squally weather, unusual for this season. Our tour has been extended till the middle of March. I hope to find some letters when I reach Trinidad.

Yours sincerely,

(Signed) EMILY E. P. MacMANUS.

Hospital Information, etc.

HOUSE APPOINTMENTS

February 1st–April 30th, 1947.

(GUY'S)

OUT-PATIENT OFFICERS.

E. M. M. Besterman
J. Crossley
M. G. D. Davys
A. P. Baker

HOUSE PHYSICIANS.

I. A. H. Munro, J. T. Woodall	Dr. Marshall, Dr. Hampson and Dr. Baker
R. U. F. Kynaston*, B. Rowlatt*	Dr. Campbell and Dr. Mann
R. C. Hallam*, I. S. Eve*	Sir John Conybeare and Dr. Boland
H. B. F. Ordish*, D. H. Broughton*	Dr. Douthwaite and Dr. Hardwick

HOUSE SURGEONS.

R. G. Watson	Mr. Slesinger and Mr. Brock
G. F. Barnes	Sir Heneage Ogilvie and Mr. Atkins
J. W. A. Crabtree*	Mr. Eckhoff and Mr. Blackburn
M. M. Figgis*	Mr. Massie and Mr. Wass

RESIDENT OBSTETRICIANS.

G. T. Hammond*	Feb. 1st.
D. H. Crook*	Mar. 1st.
G. J. Amiel*	Apr. 1st.

CHILDREN'S HOUSE PHYSICIANS.

G. W. Downes*
W. H. Humphreys*

EAR & THROAT HOUSE SURGEON.

C. N. de'E. Eastes*

OPHTHALMIC HOUSE SURGEON.

W. E. S. Bain*

FRACTURE HOUSE SURGEON.

E. W. Crews*

BACK SURGERY HOUSE SURGEON.

G. J. L. Davies* Mar. 1st.

NEUROLOGICAL HOUSE PHYSICIAN.

G. R. McK. Sichel

DERMATOLOGICAL HOUSE PHYSICIAN.

J. D. Everall*

HOUSE SURGEON (**Orpington**).

D. Walker

EAR & THROAT HOUSE SURGEON.

S. G. A. Shute

HOUSE SURGEON (**Farnborough**).

T. N. Reynolds, B.2

MEDICAL OFFICERS (**Southern**).

H. Herbert	Feb. 1st.
S. L. O. Jackson	Mar. 1st.

HOUSE SURGEON (**Pembury**).

J. F. P. Rooney

HOUSE PHYSICIAN.

C. J. Zerny*

* Ex-Service Medical Officer.

NOTICES

DEPARTMENT OF SURGERY.

During the latter half of February there will be an exhibition in the Gordon Museum, illustrating Peptic Ulceration.

On Tuesday, February 18th, at mid-day, there will be a further demonstration in the series of operative procedures in Theatre II.

On Saturday, March 1st, at 10.30 a.m., there will be a Clinico-Pathological meeting in the Clinical Theatre; all students and qualified men are welcome.

H. J. B. ATKINS,
Director of the Surgical Department.

SIR ALFRED FRIPP MEMORIAL FELLOWSHIP.

The Sir Alfred Fripp Memorial Fellowship in Child Psychology at Guy's Hospital, open to medical graduates, men or women under the age of 35, preferably with experience in Pædiatrics as well as in Psychological Medicine. Stipend £250 a year. This appointment is for two years and may be held concurrently with a part-time appointment elsewhere. Applications (10 copies) should be forwarded to the Dean, Guy's Hospital Medical School, London Bridge (from whom copies of the regulations may be obtained), together with the names of three referees. Applicants should submit a definite scheme of advanced

study or research work to be carried out during the tenure of the Fellowship together with particulars of their previous career. Applications should be forwarded by the 28th February.

PHYSICAL SOCIETY.

Treasurer's Prize Essay, 1947.

Essays for the above Prize are invited on either of the following subjects :—

"*The Influence of the Sydenham Tradition on Modern Medicine.*"

"*Applications of Atomic Energy to the Understanding of Disease.*"

Essays, for which students unqualified at time of entry only are eligible, should be submitted by 1st May.

Students and House Officers are invited to submit papers to the Physical Society to be read this Winter Session.

CHRISTIAN VOCATION IN NURSING.

A Conference on a subject that is very much in the mind of some members of the Nursing profession at the present time will be held in the Nurses' Home, Guy's Hospital, on the 27th February.

The subject is "Christian Vocation in Nursing", and members of the Nursing profession from the other teaching hospitals in London are being invited to take part in it.

The Bishop of Southwark will preside and the speakers, besides representatives from other hospitals, will include Sister Hilda Gratian, Sister Margaret Scales (who will be leaving us a few days later), and two nurses in training.

Any old Guy's nurses who are able to come to this evening Conference, which commences at 9.15 p.m., will be very welcome.

BOXING

The Guy's Hospital Boxing Club are holding their first Grand Open Boxing Tournament at Seymour Hall, Seymour Place, Marylebone, on Wednesday, 5th March, *in Aid of the Funds of Guy's Hospital.*

Guy's and St. Mary's will oppose each other in a special team match of seven bouts ; there will be a 9 st. 9 lbs. open Novices Competition and three special contests between prominent amateur boxers.

A good evening's entertainment is promised and applications for tickets should be made without delay to the Appeal Office, Guy's Hospital, S.E.1, enclosing remittance and stamped addressed envelope. Prices of admission :—

£1 ; 15*s.* ; 10*s.* 6*d.* ; 5*s.* ; 3*s.* 6*d.*

A. E. MACLAUCHLAN,
Hon. Secretary.

THE MUSIC CLUB

Rehearsals have started for Purcell's "King Arthur." They are held in the Lower Massage Gym. on Mondays at 6 p.m. All voices are welcome.

The Madrigal Group is in need of some more experienced voices, especially sopranos and altos. Those interested should communicate with Mr. J. F. Soothill.

Orchestral instrumentalists, of all standards, should get in touch with Mr. R. H. R. White, with a view to arranging ensembles.

ROBERT TAYLER,
Hon. Secretary.

APPOINTMENT

Order of St. John of Jerusalem.

Dr. J. W. Sandoe and Dr. E. E. Parrett have been appointed as serving brothers to the Venerable Order of the Hospital of St. John of Jerusalem.

Paul Borglays, L.D.S., has been appointed Honorary Dental Surgeon to the Wood Green and Southgate Hospital, Bounds Green Road, London, N.11.

AWARDS

Legion of Merit.

Brigadier E. R. Boland, C.B.E., F.R.C.P., R.A.M.C., has been created an officer of the Legion of Merit in recognition of distinguished services in the cause of the Allies.

O.B.E. (Civil).

Major Hoe Minn Sein, I.M.S., Medical Superintendent, Rangoon General Hospital.

PASS LIST

THE EXAMINING BOARD IN ENGLAND.

D.L.O.

PART I.—November, 1946.

K. L. Wilson.

SOCIETY OF APOTHECARIES OF LONDON.

FINAL EXAMINATION.

January, 1947.

Midwifery.—R. D. C. Hart.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

M.R.C.P.

January, 1947

A. G. C. Cox, M.B., Lond. ; J. B. Bainbridge, M.D., Lond. ; Eric Smith, D.M., Oxon.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

F.R.C.S.

PRIMARY EXAMINATION.

February, 1947.

A. G. Albers	R. E. Horton
W. E. S. Bain	R. Rowlandson
A. J. P. Graham	D. M. Strathie

UNIVERSITY OF LONDON.

EXAMINATION FOR THE ACADEMIC POSTGRADUATE CERTIFICATE IN PUBLIC HEALTH.

December, 1946.

A. M. McCall	G. S. Wigley
E. M. Poulton	J. H. Wildman

BIRTHS

WARREN.—On February 7th, 1947, at Epping, to Joan (née Peacock), wife of Michael Warren—a son.

BARKWORTH.—On January 26th, 1947, to Beryl (née Wright), wife of Capt. F. Basil S. Barkworth, R.A.M.C.—a son (Paul).

ROBERTSON-RITCHIE.—On January 5th, 1947, to Jane (née Marrack), wife of D. Robertson-Ritchie, L.D.S., H.D.D.—a sister for Jean (Elspeth).

MARRIAGES

WALKER—COLMAN.—On January 18th, 1947, at St. Martin-in-the-Fields, David Walker, M.R.C.S., L.R.C.P., to Rosemary Colman.

DEATHS

BISSHOPP.—On December 26th, 1946, at Tunbridge Wells Hospital, Francis Robert Bryant Bisshopp, M.D., M.R.C.P., aged 87 years.

FIDO.—On January 25th, 1947, at 22, Raleigh Gardens, S.W.2, Herbert Adamson Fido, M.R.C.S., L.R.C.P., aged 81 years.

Eds. { D.H.F. H.A.R.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LXI. No. 1529 *8th March* 1947 *Ninepence*

PASSIM

THE first duty of this belated Passim is to apologise to our readers for the delay in production of the present issue of the *Gazette*. The cause was the same as that which has been responsible for so many recent national disturbances, but to attempt a naming of the seat of the trouble would provoke such controversy that the *Gazette* would degenerate into a political pamphlet. Let it merely be said, therefore, that something seems to have gone wrong somewhere and the glorious peace has not turned out quite so rosy as was expected.

Our printers, Messrs. Ash & Co., have worked as hard as the Government would permit. They have been printing the *Gazette* for the past sixty years and, in spite of all the numerous difficulties during that time, have never failed in their duty to see that our hospital journal regularly left their printing presses. To have maintained such continuity during all those uncertain days between that gloomy September in nineteen-thirty-nine and that joyous May two years ago, is an achievement of which some pride may be felt. To be set back during the victory years is, to say the least, a little galling but, on consideration, the whole of the country seems a little off balance at the present time, and with villages buried from sight, ice-bergs almost within hailing-distance of our shores, and mouth-organ recitals at the Royal Albert Hall, one feels that anything may happen—and probably will!

Gradually, however, with the return of the temperature to points at or above freezing, the traces of the recent ice-age may disappear. Perhaps, before long, the smooth mosaic paving of the fore-court will once again be visible, and the green serenity of the park unblemished by sloughs of grey snow! The journey from the colonnade to the Medical School will be made above ground, instead of amidst the uncertain vapours of yesterday's vegetables which seem to pervade the atmosphere of the catacombs of Guy's. A stroll to the mortuary, during recent days, threatened to become a one-way trip, while early morning lectures in the Gordon Museum or Physiology Theatre did their best to provide the wards with cases of frost-bite.

In spite of incessant and, presumably, well-meaning clankings of central-heating pipes in various corners of the hospital buildings, a steady "north-easter" seemed to be provided especially for those who sought to linger, and lecturers and audiences alike refused to doff their overcoats. One was made very forcibly aware of the extraordinary fact that there seem to exist only two kinds of hospital radiator—the first designed, it would seem, for the comfort of cases of Thyrotoxicosis, that is, producing no heat at all, and the second, a much more formidable type, guaranteed to yield an immediate third degree burn on any chance contact.

England is renowned for its eccentric weather and, whilst anticipating such exciting conditions as a sand-storm or a plague of locusts during the present month, we do at least hope for some Spring sunshine, be it only to light our steps along the weary paths to Kensington and Queen Square.

OWING to the generosity of the Master and Wardens of the Clothworkers' Company in this country, and the Johns Hopkins Foundation in America, it has been possible to arrange, at least for a number of years, an interchange of teachers between the Johns Hopkins Hospital and Guy's. It is proposed that two members of the staff of Guy's visit the Johns Hopkins Hospital for at least a month each year and in return two members of that hospital will visit us.

This scheme is the first of its kind and we know that Guy's will benefit from it enormously. For one month in each year we shall have the advantage of teaching from American Physicians and Surgeons brought up and trained in an entirely different atmosphere and tradition. Our visitors will bring back from America fresh ideas and fresh inspiration, and we must see to it that the Johns Hopkins Hospital benefits equally.

Our two representatives this year are Sir Charles Symonds and Mr. Eckhoff, so we need have no concern that, with these two ambassadors of Guy's, our reputation in Baltimore will be not only finely sustained but enhanced. It is also necessary, when our visitors arrive, that they should see that this hospital, crippled though it may be in accommodation, is yet well informed and that in every department there exists that inspiration and vigour which they will have been lead to expect from the foundation which nurtured Astley Cooper and Bright.

This year it is rumoured that it will be our good fortune to entertain the Professors of Medicine and Surgery. We feel that it is conferring on our hospital the greatest honour that these distinguished American consultants should come to us as associate members of our staff, and in extending to them our most cordial welcome we trust that on their return to America they will carry with them happy and stimulating memories of their stay with us.

Obesity

A Clinical Lecture given by P. M. F. BISHOP, D.M., on July 22nd, 1946.

GENTLEMEN,—During this period of bread rationing it may seem inappropriate to choose the subject of obesity to discuss with you. Nevertheless in spite of our present dietary plight there are still in this fair island many citizens who are not only loyal but stout.

THE PHYSIOLOGY OF OBESITY.

Let us first remind ourselves of certain simple physiological principles.

Food Substances.—The five main constituents of food are protein, carbohydrate, fat, water and salts.

Fat is the obvious and direct source of over-weight. Primarily it is the reserve food substance which is stored in the depôts of the body, though it may provide a highly concentrated source of energy, for its calorie value is twice that of either of the other food substances. In this country excessive consumption of fat is a relatively uncommon cause of obesity, though on the

continent where cream, butter and rich oily dishes were liberally consumed, a type of flabby adiposity was not uncommon before the war. *Carbohydrate* is the chief source of our nourishment and thus the key to alimentary obesity. Like contemporary British Wheat supplies, it is not stored, except in the "pipe-line" of the liver. It is primarily utilised to provide the heat and energy of the body. Should it be consumed in excess of these requirements, however, it may be converted into fat and stored as such. Conversely, should inadequate quantities of carbohydrate be available to satisfy the needs of bodily activity, fat may be converted to carbohydrate, and the fat stores depleted. *Protein* plays no direct part in balancing the weight of the body, though by its specific dynamic action it facilitates the utilisation of other food substances which might otherwise be stored. In some cases of obesity, especially those due to pituitary deficiency, retention of *water* is an important factor, and this is facilitated by retention of certain *salts*, especially chloride. These facts are summarised diagramatically in Fig. 1.

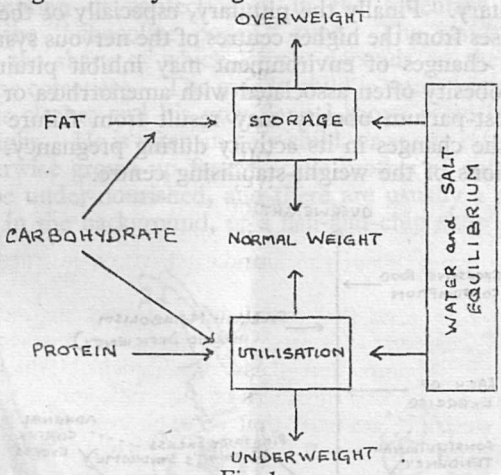


Fig. 1

THE WEIGHT-STABILISING CENTRE.

Perhaps the most remarkable fact about body-weight is its constancy. This is an example of what W. B. Cannon called the "homeostasis" of the body. Other examples are the delicate control of the blood-sugar level, and the stability of body temperature. The latter is maintained by the temperature-regulating centre, and should this be affected by the toxins of any so-called "febrile" illness, the temperature will "swing" or the centre become "geared" to work at a higher level. It may be supposed that there is likewise a "weight-stabilising centre" probably situated in the region of the hypothalamus on the nervous pathway between the supra-optic nucleus and the anterior pituitary. Its capacity to stabilise weight is of course subject to great individual variation, and in certain people there is undoubtedly a constitutional or genetic ineffectiveness of the centre with a consequent tendency to put on weight after the slightest dietary indiscretion. On the other hand, in the normal person the centre "buffers" episodes of dietary debauch or slothful siesta, so that within certain limits they may be indulged in with impunity, though of course even in a normal individual constant excessive food consumption and lack of exercise will overstrain the centre, and weight will

gradually be gained. Similarly, chronic "wasting" disease or prolonged semi-starvation will lead to steady loss of weight. Again, the centre may be incapable of combating extreme variations in metabolic rate and the increased oxygen consumption of thyrotoxicosis may result in underweight, whereas the opposite may be induced by the sluggish metabolic processes of myxœdema or cretinism.

The centre itself is most intimately associated with the functional activity of the anterior pituitary, and it is probably the various influences on this gland, both nervous and hormonal, which are responsible for the different types of endocrine obesity. Gross pituitary failure gives rise to the cachexia of Simmonds' Disease, whereas mild pituitary deficiency may result in "pituitary obesity" or Fröhlich's syndrome, and over-activity of the basophil cells, be it primary or secondary to adrenal cortical hyperplasia, leads to the characteristic obesity of Cushing's syndrome. Thyroid and gonadal deficiency, though each may be identified by obesity of typical distribution, may act through the pituitary. Finally the pituitary, especially of the female, may be sensitive to impulses from the higher centres of the nervous system. Emotional disturbances and changes of environment may inhibit pituitary activity and lead to pituitary obesity often associated with amenorrhœa or other menstrual disturbances. Post-partum obesity may result from failure of the pituitary to recover from the changes in its activity during pregnancy. Figure 2 summarises the reactions of the weight-stabilising centre.

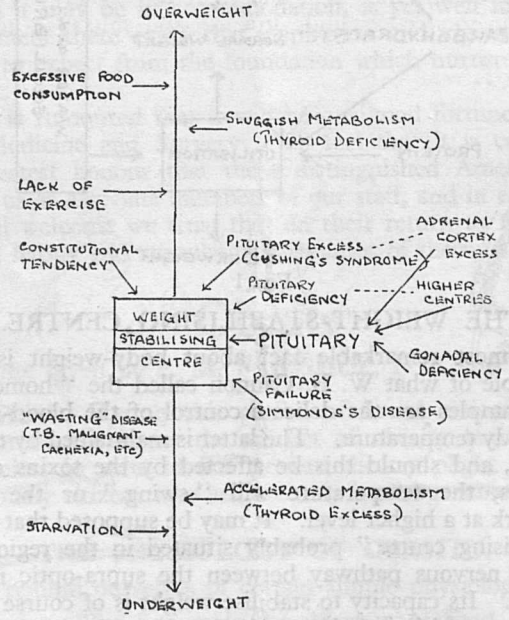


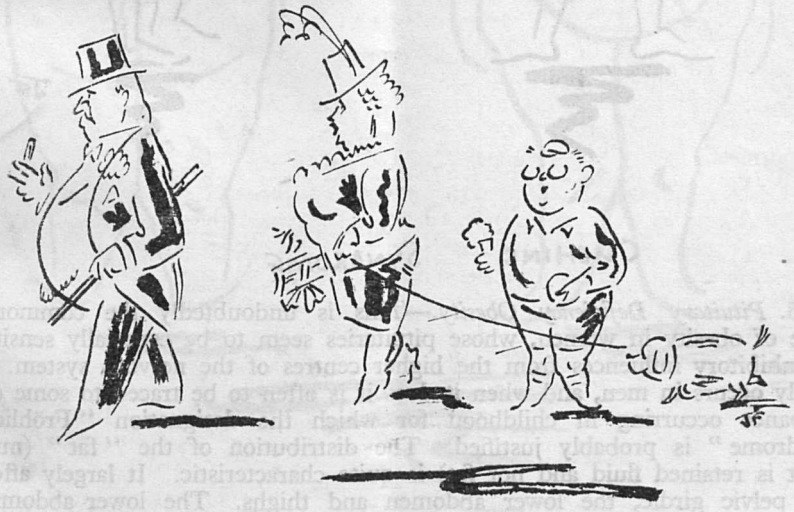
Fig. 2

CLINICAL TYPES OF OBESITY.

Three main types of obesity may be recognised clinically.

1. *Exogenons, alimentary or gluttonous obesity.*—Though probably the commonest form, it will seldom be seen in the consulting room or out-patient

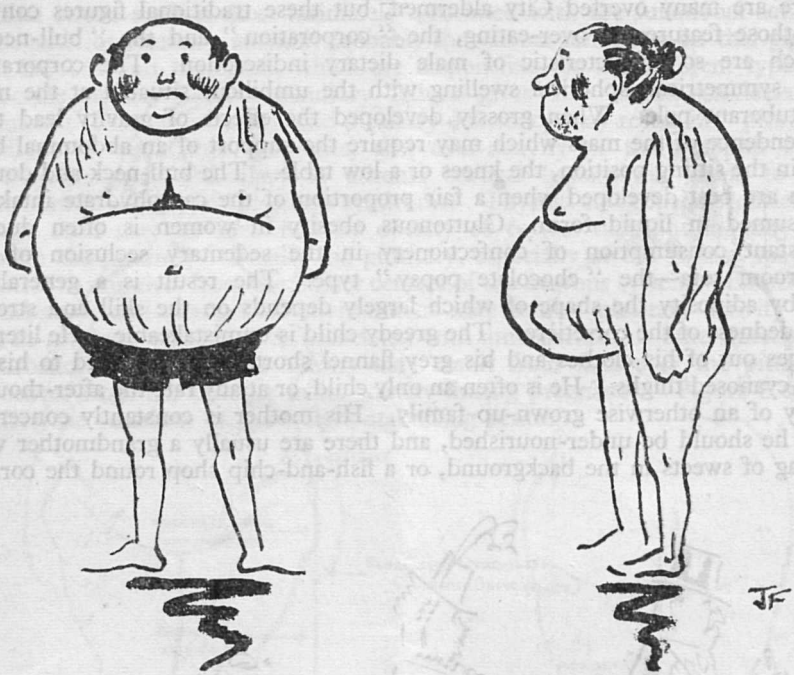
department, for the last thing the glutton wants is treatment. It must therefore be studied in the restaurant, the boudoir and the play-room. It affects men, women and children. In men it is certainly the commonest cause of obesity, for men on the whole are more greedy than women, and furthermore the male pituitary is relatively singularly restistant to functional damage. This may be described as the " City alderman type," not that, at the present time, alas, there are many overfed City aldermen, but these traditional figures conjure up those features of over-eating, the " corporation " and the " bull-neck " which are so characteristic of male dietary indiscretion. The corporation is a symmetrical, spherical swelling with the umbilicus situated at the most protuberant pole. When grossly developed the effects of gravity lead to a dependence of the mass which may require the support of an abdominal belt, or, in the sitting position, the knees or a low table. The bull-neck and double chin are best developed when a fair proportion of the carbohydrate intake is consumed in liquid form. Gluttonous obesity in women is often due to constant consumption of confectionery in the sedentary seclusion of the bedroom sofa—the " chocolate popsy " type. The result is a generalised flabby adiposity the shape of which largely depends on the skill and strong-mindedness of the corsetière. The greedy child is unmistakeable. He literally bulges out of his clothes and his grey flannel shorts seem moulded to his fat and cyanosed thighs. He is often an only child, or at any rate the after-thought baby of an otherwise grown-up family. His mother is constantly concerned lest he should be under-nourished, and there are usually a grandmother with a bag of sweets in the background, or a fish-and-chip shop round the corner.



ALIMENTARY OBESITY

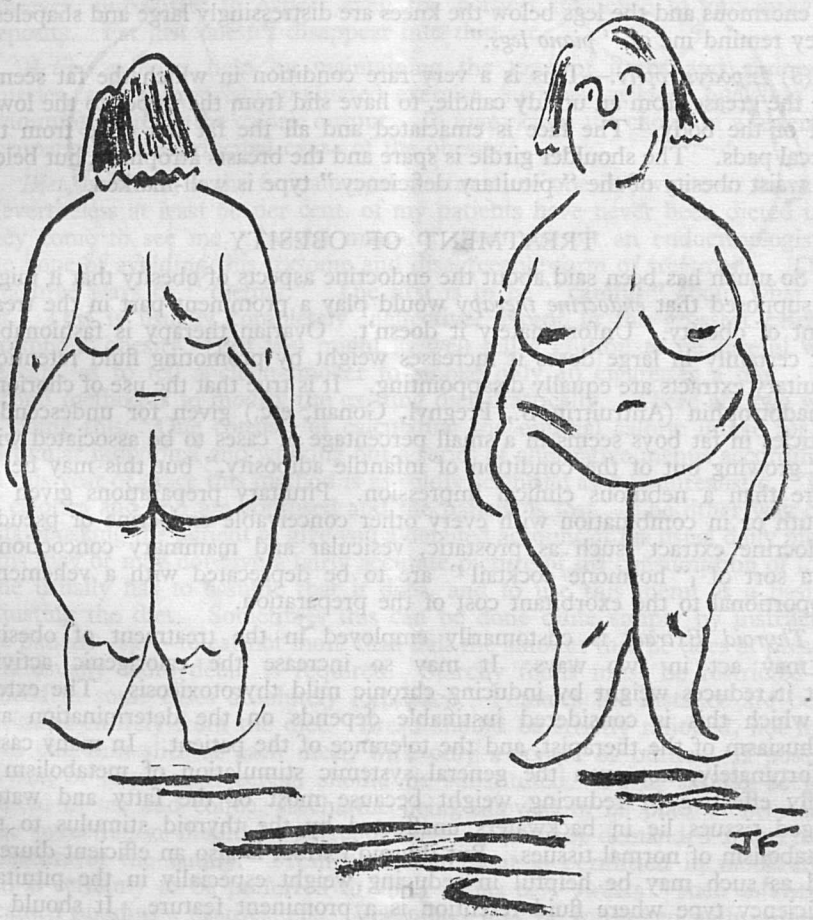
2. *The " Cushing " type.*—Here the obesity stops short at the hips, and the relatively spindly legs may seem inadequate to support the large oval mass above them. Thi appearance conjures up a picture of a lemon on toothpicks. The face is large and round like a full moon and plethoric. The neck may be hidden by a double chin and a " Dowager's hump." The shoulder

girdle is massive and scarlet or purple striæ may emerge from the axilla as though to interlock with those that radiate upwards from the hips, flanks and lower abdomen. The breasts in the female may be either atrophied or, as they are in the male, fatty and prominent. The abdomen protrudes as in a full-term pregnancy, which many of the female victims are suspected by their neighbours of carrying.



3. *Pituitary Deficiency Obesity*.—This is undoubtedly the commonest type of obesity in women, whose pituitaries seem to be especially sensitive to inhibitory influences from the higher centres of the nervous system. It rarely occurs in men, and when it does it is often to be traced to some disturbance occurring in childhood for which the designation "Fröhlich's syndrome" is probably justified. The distribution of the "fat" (much of it is retained fluid and not fat) is quite characteristic. It largely affects the pelvic girdle, the lower abdomen and thighs. The lower abdominal "apron" hangs down over the pubis, and in the male may to some extent hide the pubic "sporan." The hips shelve laterally and the prominent buttocks form in profile a well-defined "bustle." Posteriorly the fold beneath the buttocks and the vertical cleft which separates them forms with the line demarcating the two thighs a characteristic "hot-cross bun" marking. In front localised lipomata on the inner aspects of the thighs and similar swellings in the popliteal fossa may be described as the "crutch" and "popliteal" pads. Knock-knees and flat feet are the obvious mechanical

results of excessive bulk. A reduplicated fold of fat hangs down from the subscapular regions as a " shoulder cape," and a " dewlap " can often be detected above the elbows. Large pendulous breasts complete the picture. In some of my cases the apron and the breasts have been so gross as to require surgical removal. In " Fröhlich " boys the pubic " sporran " often suggests that the penis is diminutive. This is frequently not the case, and at least two of my small series of men with " Fröhlich's " disease are proud fathers. Most children with this condition are myopic and wear glasses.



PITUITARY TYPE

Apart from these three types there are five rarer groups in which the obesity is very characteristic.

(1) *Cretinous Obesity*.—The pot-belly with protruding umbilicus, the supra-clavicular pads and the fat, stupid facies with lolling tongue and bags under the eyes are unmistakeable.

(2) In women who have been *castrated* early in life there sometimes develops a localised obesity of the hips so marked that it has been aptly described as the "riding breeches" type.

(3) There is a group in which the obesity is confined to the hips, thighs and legs, the upper part of the body remaining normal. Zondek refers to this as "*thyropituitary obesity*." In the one case I have investigated fully, the B.M.R. was normal.

(4) In another group the obesity is confined to the legs. The thighs are enormous and the legs below the knees are distressingly large and shapeless. They remind me of "*piano legs*."

(5) *Lipodystrophy*.—This is a very rare condition in which the fat seems, like the grease from an untidy candle, to have slid from the upper to the lower half of the body. The face is emaciated and all the fat has gone from the buccal pads. The shoulder girdle is spare and the breasts atrophied, but below the waist obesity of the "pituitary deficiency" type is well-marked.

TREATMENT OF OBESITY.

So much has been said about the endocrine aspects of obesity that it might be supposed that *endocrine therapy* would play a prominent part in the treatment of obesity. Unfortunately it doesn't. Ovarian therapy is fashionable, but certainly in large doses it increases weight by promoting fluid retention. Pituitary extracts are equally disappointing. It is true that the use of chorionic gonadotrophin (Antruitrin S., Pregnyl, Gonan, etc.) given for undescended testicles in fat boys seems in a small percentage of cases to be associated with a "growing out of the condition of infantile adiposity," but this may be no more than a nebulous clinical impression. Pituitary preparations given by mouth or in combination with every other conceivable endocrine or pseudo-endocrine extract (such as prostatic, vesicular and mammary concoctions), as a sort of "hormone cocktail" are to be deprecated with a vehemence proportional to the exorbitant cost of the preparation.

Thyroid Extract is customarily employed in the treatment of obesity. It may act in two ways. It may so increase the calorigenic activity that it reduces weight by inducing chronic mild thyrotoxicosis. The extent to which this is considered justifiable depends on the determination and enthusiasm of the therapist, and the tolerance of the patient. In many cases, unfortunately, not even the general systemic stimulation of metabolism is really effective in reducing weight because most of the fatty and water-logged tissues lie in backwaters unaffected by the thyroid stimulus to the metabolism of normal tissues. But thyroid extract is also an efficient diuretic and as such may be helpful in reducing weight especially in the pituitary deficiency type where fluid retention is a prominent feature. It should be given in initial doses of $1\frac{1}{2}$ gr. daily, and the dose increased by $\frac{1}{2}$ gr. daily every three weeks until the pulse rate reaches 90, or unpleasant toxic symptoms appear.

Other *diuretics* may play a useful part in treatment. Passive fluid elimination by inducing sweating with hot baths, Turkish baths, wax baths, electric cradle and warm blankets may be useful in subjects who perspire freely. Fluid restriction to not more than $1\frac{1}{2}$ to 2 pints daily should be enforced (it is remarkable that most people do not in fact ordinarily consume more than 2 pints of liquid refreshment daily). Table salt should be prohibited. Active diuresis may be prescribed in various forms. An effective method is to give

2 c.c. of mersalyl intramuscularly twice weekly with three capsules of ammonium chloride, gr. 30, on the day before each injection. Some patients do not tolerate mersalyl well, and it must not, of course, be administered where there is any evidence of renal damage. It must always be given with some caution.

Massage and passive exercise are indicated on the ground that like the rolling stone that gathers no moss, active muscle is unlikely to deposit fat in its vicinity. It is for this reason that hands and feet are seldom fat. It is, however, unrealistic to expect even the heftiest masseuse to rub away fat deposits. Fat just doesn't disappear into thin air.

Active exercises help by maintaining the tone of limbs and abdominal muscles, and appropriate graduated exercise, such as walking, bicycling and swimming increase the calorie output. In many cases the choice of a sedentary occupation is the principal cause of the obesity.

Diet, however, is the fundamental treatment of obesity, whatever its cause. Nevertheless at least 50 per cent. of my patients have never been dieted until they come to see me. Indeed many of them consult an endocrinologist in the hope of avoiding this irksome and disagreeable form of treatment. There are three ways of "dieting." The first is to be "careful" about what you eat. This is usually completely ineffective, except in the grossest cases of gluttonous obesity. But you might as well tell a glutton to be careful what he eats, as to tell a chain-smoker to smoke only 10 cigarettes a day. The second method is to modify the existing diet drastically. There are two ways of doing this. One consists of calculating the optimal calorie intake for the particular individual and working out a series of alternative menus accordingly. In this year of grace this method is as coldly scientific as it is unrealistic. Talk of calories and you are confused and the patient is lost. The other way consists of asking the patient to give you a detailed account of his usual daily menu. This may or may not give a fairly accurate picture of his consumption of food. One usually has to assume that it does, and to use this menu as a basis of adjusting the diet. Sometimes this can be done quite simply by instructing the patient—say—to eat not more than half the amount that he does at present. But usually more detail is required. Starchy foods must be restricted—or indeed in some cases absolutely forbidden. Potatoes for instance are better excluded entirely from the diet. Bread should be strictly rationed, not more than one thin slice at each meal, with only a scrape of butter. If possible Ryvita, or some such cereal, should be substituted. Sugar should be prohibited in tea and coffee, saccharine being allowed in its place if necessary. The sweet ration should be surrendered to, instead of demanded from, other members of the family. Fresh or stewed fruit is permitted in moderation, and is certainly to be preferred to other forms of "sweets" such as suet or steamed puddings, pastries, etc. Vegetables may be consumed with impunity other than those which begin with the letters P or B such as potatoes, parsnips, peas, broadbeans and beetroot. Lettuce and other salad constituents are especially suitable as they give a sense of fullness without contributing appreciably to the calorie intake. Fried foods should be strictly avoided. Lean meat, and especially white meat, such as chicken and game, and inexpensive white fish, especially if boiled, steamed or baked, and cheese in moderation may be encouraged. In addition to the prescription of such a diet, it is important that the patient should be weighed regularly, on the same day of the week, at the same hour of the day, and on the same scales and so far as is

possible, in the same clothes. A steady loss of two pounds a week should be achieved. The third method consists in starvation. The patient is admitted to hospital, preferably to a single room rather than a ward, and is given 2 Ryvita biscuits and 1½ pints of fluid—consisting of water, fresh squeezed orange, grapefruit, etc.—daily, for 10 days or a fortnight. During this time massage, exercises, hot baths, thyroid, etc., are also given, and in some cases diuretic treatment in the form of mersalyl and ammonium chloride. The patient is weighed every other day and the strict starvation regime continued until the weight curve begins to flatten out. For the first week or so, the two daily loss of weight will be 2 to 4 lbs. but towards the end of the second week it will decrease to 1 or 2 lb. When this happens some relaxation is allowed and restricted quantities of food such as a tomato, a piece of lettuce, a piece of lean cold beef, a little jelly, etc., may be given. This drastic treatment usually results in a loss of 1½ to 2 stone in 3 weeks, and furthermore it has the great advantage that the patient loses his appetite completely during the first week, and may not regain it for some months, and so is able to live on a very low calorie diet for some time after discharge from hospital.

Of the three methods of dietary treatment the last is in my opinion the most satisfactory, but it does require careful supervision in a hospital or nursing home.

But is treatment necessary in every case of obesity? In children and young adults it is certainly desirable. In middle or old age however the body has so conformed to its characteristic stoutness that treatment is less likely to be effective, and there are many middle-aged or elderly fat men and women whose comfortable and cheerful outlook on life would not be altered for the better by a reduction of a few stone in their weight. It is as well to bear in mind the sensible opinion of Shakespeare's Julius Cæsar :—

> " Let me have men about me that are fat,
> Sleek-headed men, and such as sleep o'nights,
> 'Yond Cassius has a lean and hungry look,
> He thinks too much : such men are dangerous."

(My grateful thanks are due to Dr. John Forbes for his amusing caricatures of the various types of obesity.)

Review

" 99 " *and All That.* Leaves from a M.O.'s Notebook. By FREDERICK HAIGH. Richard Lesley & Co. 1946. Pp. 261. *Price* 9*s.* 6*d.*

AFTER a bit of hesitation one must conclude that this is written by a Guy's man. He is about 54 years of age and I think his contemporaries should easily spot him although he claims he is unrecognisable. He has had many experiences in many parts of the world, the most striking of which must have been the sight of the ice cliffs of the south polar cap into which his ship nearly ran in a storm that struck them when off Durban. His account shows how quickly the life of a hospital changes in a few years, for much of what he writes is unknown to me. I remember the underground room of the old Anatomical Department which contained the tanks for dissection material ; but never knew that a miniature rifle range was ever there, nor of the High Court of Anatomy, or of the stark brutality which was practised on one occasion with a terrible result. It is doubtful whether such things should be put on record. They suggest that the Guy's man of to-day is a coarser youth than was Mr. Robert Sawyer. Mr. Haigh had a remarkable set of acquaintances, of whom the lovable one was George who cleared out and never qualified for love of a Sister. The others were tough nuts, to put it mildly ; the negro who seduced a woman by a mock marriage ; the other one

who kept a first-rate nursing home with his 16 wives as staff; the South African who tried to cheat him of his Derby Day winnings; the Irishman who knew no midder but much foul language; the failure who committed suicide in a toast of cyanide; and the artist who joined the Black-and-Tans. It must have been quite unusual for anyone to have known so many curious Guy students, and gives a wrong picture of hospital life. Such a group has had no real influence in the life of the hospital.

The story of the beer is wrongly told; it was not paid for by an old gentleman with a broken leg who owned a flourishing brewery. It was paid for by the dressers for the week; and to be a take-in dresser was a severe strain on father's pocket. It cost at least £5 for the week, and that meant doing things with some stinginess in a week in which one was a resident and got board and lodging free.

I have often started to estimate how many times Mr. Pickwick took more alcohol than was good for him. If one made a similar reckoning in this book the number of times would be as many, with this difference that Mr. Pickwick's alcoholism was associated with geniality, alcoholism here starts "viciously" and ends up "in indecorous hilarity." I have long taught that it may be advisable, though not essential, for every student to study the action of alcohol practically on one occasion and possibly two; but that these occasions must occur before qualification. Once that is passed the medical man should aim at an absolute standard of non-repetition. It is therefore a pity that in a profession in which there are always apt to be failures to attain to this rule occasional alcoholism in a member of our profession who has at different times been a "Harley Street" specialist in London, Provinces, Dominions and Colonies, and a general practitioner in nearly as many different places should appear not merely as a venal medical misdemeanour but as actually heroic.

With all this there is something attractive in the fellow and his heart is in the right place with his admiration for saints, his active sympathy for the under-dog whether he be the Boro' patient or the Welsh miner, and his power of mixing with all men, from an ex-Boer general to the guards of a Portuguese frontier post. T. B. L.

A Short Handbook of Practical Anæsthetics. By HÖEL PARRY-PRICE, M.R.C.S., L.R.C.P. Published by John Wright & Son, Ltd., Bristol. *Price* 12*s.* 6*d.*

THIS book is interesting to read and contains much sound practical advice on the administration of anæsthetics. It is obviously written by a man who has had considerable experience and is enthusiastic about his subject. It is in no sense a text-book of anæsthetics and, being written from a personal standpoint, tends to be dogmatic in places. Statements are made, many of them sound in themselves but not supported by any satisfactory evidence. For example, it is baldly stated that "Avertin" causes an increased risk of secondary hæmorrhage in brain surgery, without any supporting illustrations. The statement elsewhere that "static electricity need hardly be considered in this country" in a paragraph on the risk of explosion, is, to say the least of it, rash in a book written by an anæsthetist. Statements like this keep arresting the smooth reading of the book as evidence is sought for and not found for these suggestions. Similarly several split infinitives and careless arrangement of subject matter cause irritation.

Indeed, this book would more accurately be described as a series of personal experiences and anecdotes gained from twenty-five years practice of anæsthetics. Some of these are excellent, for example, there is a chapter on "anæsthetics for the nursing staff," which explains all the practical details of administration such as the need for silence during induction and a brief description of the various apparatus. Emphasis is laid on the adequacy of small doses of anæsthetic agents, and a valuable plea is made for the exclusion of such barbaric instruments as tongue forceps and metal gags from the anæsthetist's trolley.

It is a small book and well worth reading by anyone interested in anæsthetics. It is not, however, a quick way of learning the "essentials of anæsthesia." T.H.S.B.

Hospital Information, etc.

NOTICES

APPOINTMENTS VACANT.

Applications are invited from Registered Medical Practitioners for the appointment of Registrar (B.1) (whole-time) in the Dermatological Department at Guy's Hospital. The appointment is for two years, salary £500 per annum. Forms of application may be obtained from The Dean, Guy's Hospital Medical School, to whom applications, together with names of three referees, should be forwarded not later than 31st March, 1947.

Applications are invited for the appointment of a whole-time EX-SERVICE SPECIALIST in the EAR, NOSE AND THROAT DEPARTMENT, under the Ministry of Health Scheme for Additional Specialist Appointments. Salary £1,000 per annum. The duration of the appointment will be limited to the interim period pending the establishment of the National Health Service (April 1st, 1948). Applications (20 copies), giving the names of three referees, should be lodged with the Dean, Guy's Hospital Medical School, London Bridge, S.E.1, not later than 31st March, 1947.

DEPARTMENT OF SURGERY.

On Saturday, March 8th, at 10.0 a.m., Sir Stanford Cade will conduct a departmental round in Queen Ward.

On Monday, March 10th, at 5.0 p.m. in the Anatomy Lecture Theatre, there will be a film demonstrating the treatment of varicose veins.

H. J. B. ATKINS,
Director of the Surgical Department.

PASS LIST

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

M.R.C.P.

January, 1947.

J. B. Robinson, M.D.

CONJOINT BOARD.

FINAL EXAMINATION.

January, 1947.

Pathology.

M. B. Conran — J. M. Rahilly
R. French — R. L. Timms
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*H. Herbert — *D. Walker
C. D. Korn

Midwifery.

L. J. Evered — A. L. Jeanes
J. J. Fingard — C. D. Korn
J. M. Hall — *J. Niwes

* Have now completed the examination.

SCHOLARSHIP AWARD.

W. G. Cross, M.B., B.S., B.D.S., has been awarded the Ernest Hart Memorial Scholarship by the B.M.A. for a specific object in Research.

PAPERS BY GUY'S MEN

Nissim, J. A. Spiral wash-outs in the treatment of purulent meningitis. *Brit. Med. J.*, 1947, i, 176.

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Thompson, R. H. S. The action of chemical vesicants on cholinesterase. *Ibid.*, 370.

Norman, Mrs. E. Anxious parents and problem children. *Nursing Times*, 1947, **43**, 131.

CHANGES OF ADDRESS

Christopher Hardwick, M.D., Keats House, Guy's Hospital, S.E.1., and The Red House, Calvert Road, Dorking. (Tel.: Hop 0151 and Dorking 2055.)

Max Honigsberger, M.R.C.S., M.R.C.P., New Street Chambers, New Street, Birmingham, and 6, Herbert Road, Solihull, Birmingham. (Tel.: Solihull 2929.)

Miss A. N. Monaghan M. Branch, HQ., B.M.A., Cyrenaica, M.E.F. 6.

C. R. Neve, F/O. R.A.F., 202950, R.A.F. Hospital, Karachi, India Command.

P. V. Reading, Major, R.A.M.C. (371832), B.H.M., Fayid, M.E.L.F.

H. F. W. Dornhorst, L.D.S., R.C.S.Eng., Box 502, Salisbury, Southern Rhodesia.

BIRTHS

CRABTREE.—On 14th February, 1947, at Guy's Hospital, to Joan (née Cory) and Jim Crabtree, M.B., B.Ch.—a daughter (Phillippa Jane).

CRIPPS. — On Monday, 3rd March, 1947, to Margot (nee Young), wife of Norman Cripps—a second son.

GORDON.—On February 8th, 1947, at Nuffield House, Guy's Hospital, to Sally (née Allingham), wife of Dr. John Gordon, of Esher—a son.

PUSEY.—On February 13th, 1947, at Nuffield House, to Diana (née Moseley), wife of R. F. Pusey—a son.

SHIRE.—On 23rd January, 1947, at Nuffield House, to Rena, wife of T. Hugh Shire—a second son.

WHITE.—On December 7th, 1946, at Dr. Jessop Hospital, Sheffield, to Audrey (née Kinder), wife of Dr. Douglas A. White—a daughter (Alison Jane).

YOUNG.—On February 23rd, 1947, at Guy's Hospital, to Marie, wife of Dr. F. Robert M. Young—a daughter (Caroline Mackinlay).

MARRIAGES

ALLEN—COLLINS.—On February 1st, 1947, at the Savoy Chapel, Richard Allen, M.B., R.A.F.V.R., of Bridlington, Yorkshire, to Judy Collins, M.C.S.P., of Bromley, Kent.

JENMAN—TALBOT.—On Saturday, February 8th, 1947, at Fawkham, Kent, James L. Jenman, M.R.C.S., L.R.C.P., to Dorothy Talbot.

MANDEVILLE—BARTHA.—On February 1st, 1947, at Graz, Austria, F. J. Mandeville to Phyllis Bartha, S.R.N.

VINE—WALDEN.—On December 23rd, 1946, in Penang, Malaya, Sydney Maudsley Vine to Denise Walden.

DEATHS

TONGUE.—On February 14th, 1947, at 8, Longfellow Road, Worthing, Edwin John Tongue, of Winterton, Lincs. (Surgeon R.N.V.R., 1914–18).

EDS. {D.H.F. H.A.R.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

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PASSIM

THERE are some patients who are almost as much a part of Guy's as the colonnade or the front quadrangle itself. They are our most regular visitors. They have been coming here ("man and boy," many of them) for as long as the Hospital's oldest servants can remember. Originally they must have attended for diagnosis and treatment, but that was many moons ago. ("It was a hard winter that year in the Crimea.") Some of them still come for their own benefit, but many just come for ours, by invitation, and not without a little of party spirit. They come for the preclinical class and for the Fellowship course. They come many times a year and take a taxi, fare paid, to Queens Square. (They are probably the only people who have ever been known to enjoy attending that place of evil association. They can nearly always reckon to meet a few old friends, fellow visitors, not recurrent examinees !). Year after year they come. Year after year they are man handled. Year after year they tell their story, and one often wonders if that story doesn't grow just a little with the repeated telling, to conform even more perfectly with the chapter in the books. Year after year they demonstrate their gait, waggle their flail limb, turn on their side to display their mitral murmur or do whatever is their stock in trade to give us value for our money. They are the specialists. They pass us or fail us. Some praise us when we do right, some instruct us how to do right, and some just smile an infuriatingly knowing smile at our errors of technique or when we miss the point, and just won't say a thing. They like their visits and they are, many of them, proud of the perfection of their imperfections. With these people, even if one is number forty in the queue, one knows one need not hesitate. One is welcomed to "go the whole hog," and the bigger the tussle the more they appreciate our efforts. They are all for a thorough do.

Another, intermediate group, is composed of people largely from the Boro'. They know their Guy's, and they would not think of going elsewhere. They know what to expect and some almost feel that their case has not had full justice done to it until they have been seen on at least one teaching round, although many do begin to look a little apprehensive when for the fourth time in the day they must put down their knitting, "just pop into bed," and watch the screens being fetched.

But these are by no means the majority. There are others. They know that doctors must learn, and they know how doctors must learn, but that does not diminish their discomfort. Every examination to them is an ordeal. For such people it is impossible to make too much effort to see that one's

approach is as unembarrassing and as reassuring as possible. A hasty word or the lack of a well chosen phrase may forever discolour the picture that they take away of our hospital. A moment spent in careful introduction and an impression given of kindly interest for their welfare and their worries may allay their fears and trepidations more than we who are healthy and to whom anatomy is neuter, can understand.

At the present time, out-patient clinics are not what they were. There is no doubt that many people who have the highest regard for the judgment and skill of the hospital's officers, are preferring to go elsewhere because they cannot face up to the crowded out-patient cubicles and the ward demonstrations of a teaching establishment. If we wish to see the best clinical material, then we must see to it that this attitude of shyness is as nearly unreasonable as we can possibly make it, and that doctors can recommend our hospital to their patients with the utmost confidence in our respect for those patients feelings We must attend to the minutest details. To the medical student by the side of the half naked patient, there is only one reason for his smile and the glance at his friend, and that is the lipstick on the back of Jones' collar. To the patient who sees the smile and the glance, likewise there is but one reason—her half nakedness. In the minds of the students who gape, masked, capped and gowned, through the glass window in the door of the anæsthetic room, there is nothing but a sense of curiosity. In the mind of the patient, anxious alone at the thought of loss of consciousness and operation, there is nothing but the feeling that each has at his arm's end a long sharp knife.

A hospital rises or falls in public esteem not only on the results of its treatment, but on the level of its humanitarianism, its kindness and its care and consideration for the person as well as the patient.

THE question of the present national need for nurses and of whether an appeal should not be made, from the Christian standpoint, to young women in this country to enter the profession was the subject of an Evening Conference held at Guy's Hospital on the 27th February. About one hundred members of the nursing profession, including representatives from twelve other London hospitals, were present.

A resolution to the effect that an appeal be made through appropriate channels to young women to take up nursing, not primarily for what they could get out of it, but because it was a Christian obligation " to tend the sick " was unanimously adopted.

THE Index to Vol. LX (1946) is ready for distribution and may be obtained free of charge from the *Gazette* Office or Wills Library.

Blue Cloth Binding Cases (with Hospital Crest) are available, 3*s*. 6*d*. each, postage 3*d*. extra.

WE must apologise for a printer's error in the spelling of the author's name in the review of " 99 and All That " in our last issue. The name should read Frederick Kaigh and not Haigh as printed.

Hepatitis

A Clinical Lecture given by CHRISTOPHER HARDWICK, M.D., M.R.C.P., on 5th July, 1946.

GENTLEMEN,—Hepatitis is a subject which has lost much of the topical and pressing interest which it had a year or eighteen months ago when the war was still on, but it is a disease on which a great deal of work was done during the war, and in which new methods of approach, both pathological and clinical were used. Although the end of the tale cannot be told, at least we have come to the conclusion of a chapter in the story of the search for its cause and cure.

It was natural that interest in this disease, which had only smouldered between the wars, should be kindled afresh soon after September, 1939, for jaundice has long been recognised as one of the camp-followers of war. In the American Civil War of 1862, over 50,000 cases were reported, in the First World War it earned the name of " Kriegsicterus," (war-jaundice), amongst the Germans and in the struggle recently concluded jaundice caused almost more casualties than the Germans in the Alamein campaign.

INFECTIVE HEPATITIS.

Epidemiology.—Infective hepatitis is the modern name for what has been variously called catarrhal or epidemic jaundice. It is an infectious disease of low infectivity. The incubation period is long, usually about 30 days but it may be anything from 30–50 days. Close contact in the pre-icteric stage seems essential for its spread, though it has been suggested that in some cases it may be fly-borne. This latter method would appear unlikely in this country, for, although the infective agent has now been demonstrated in the stools, outbreaks occur chiefly in the autumn and winter months.

Pathology.—The disease is now known to be a true hepatitis. In saying this, there is a danger of falling into a mistake that was made after the last war, for it was then stated, with equal certainty, that the disease was due to a catarrhal inflammation of the larger biliary-passages, with blocking of the ampulla of Vater by inspissated mucus. This theory has had to be abandoned and our present conception is based on more certain ground. The morbid histology has been determined by the direct examination of the liver at the height of the illness by means of a liver-biopsy. This is performed under local anæsthesia with a fine trocar and cannula, which is inserted during full inspiration through the 9th intercostal space in the anterior axillary line. A syringe is then fitted to the cannula and a small plug of liver tissue is sucked up and provides sufficient material for histological examination. Under the microscope there is seen to be a central lobular necrosis with a cellular infiltration in the portal tracts. These changes may be diffuse or zonal and are usually more marked in the left lobe than in the right.

Symptoms.—These precede the jaundice by three or four, and in some cases, as many as ten days. Malaise, anorexia and nausea occur early and almost always are followed by vomiting. This latter usually occurs after a meal, but often the sight or smell of food or even a discussion about it is sufficient cause. The bowels are irregular, constipation being usual, though in some there is diarrhœa. Headache, aching abdominal pain and rarely

joint pains may occur. Itching may herald the appearance of jaundice and occasionally there may be an urticarial rash. Over and above all these symptoms there is usually a depression which may be of considerable depth. Fever is moderate.

During this prodromal period the disease may be impossible to diagnose with confidence, but a lead will be given by the urine which shows the presence of bile at an early stage. Once he becomes yellow the patient, as a rule, rapidly improves. It may be said that before this the patient feels ill, whilst afterwards he looks ill. Statistics show that within three weeks about ninety per cent. of patients have recovered.

Signs.—The jaundice, occurring first in the sclera has been mentioned. In about half the cases the liver may be enlarged and in about one-fifth there may be a concomitant enlargement of the spleen.

The rashes, which are not common, are usually urticarial but may be morbilliform.

Laboratory Diagnosis.—Tests for bilinuria are important both for purposes of diagnosis and as a guide to prognosis. *A qualitative van den Bergh* is a waste of time once jaundice is present, but a *quantitative van den Bergh* is of some value as a measure of the severity of the disease and as a guide in determining when it is safe to allow the patient to return to full activity. *A differential white cell count* may be of great value in excluding more serious diseases; in infective hepatitis the count is normal.

Many attempts have been made to devise tests of *liver function*—to measure the degree of liver damage that has occurred. The liver, however, is a large organ and as health may be maintained with a relatively small amount of intact tissue this problem is difficult. In the tests that have so far been devised abnormal results are only given when the amount of liver destroyed is excessive and by then the patient's serious clinical condition is a good measure of the damage that has occurred. They are of value, however, in the protracted case when they will give an unbiassed opinion as to the progress of the patient and may serve as a salutary correction to a false clinical impression.

The *intravenous Hippuric Acid test* of Quick is the simplest one to apply and has the merits of being quite safe. 1·7 grams of benzoic acid in 20 c.c. of sterile water are injected intravenously under basal conditions; this is synthesised in the liver and the percentage which is excreted in the urine as hippuric acid after one and two hours is estimated. Normal figures are over 35 per cent. in the first hour and 65 per cent. in the second hour.

An *estimation of the plasma proteins* may be of value in the long continued case. An increase of the globulin to above 3 grams, with an inversion of the albumen : globulin ratio is of particularly grave prognosis.

Differential Diagnosis.—Once the jaundice appears after a few days of vague illness the diagnosis is easy. Difficulty occurs in the pre-icteric stage and in the long continued cases, especially in elderly people.

In the first instance, influenza, glandular, typhoid and undulant fevers must all be considered. The slow pulse which occurs in both typhoid and hepatitis may be particularly misleading. When the disease is at its height, Weil's disease may have to be excluded; this may be done by a white count which shows a leucocytosis and by the specific agglutinations, which will be positive, and by the finding of the spirochætes by dark-ground illumination

of the urine which has been rendered alkaline by large doses of pot. cit. Glandular fever may also be confusing, but here again a differential white count will be of great value.

In the middle-aged and elderly the differentiation between this disease and that due to an obstructive jaundice from a growth or gall stones may be peculiarly difficult. Attempts to distinguish between the two in the laboratory have been disappointing—the thymol turbidity test for instance, has proved untrustworthy in practice. Where real doubt exists the diagnosis must be clinched by laparotomy and before this is done full doses of vitamin K must always be given intravenously.

Course and complications.—In the vast majority of cases infective hepatitis is a mild, self-limited illness of about three weeks duration. Occasionally it may progress to acute or sub-acute yellow atrophy which is fatal. More commonly relapses or recrudescences occur and in these the illness is usually more protracted and severe than in the original.

Treatment.—If the true pathology of the disease as shown by liver biopsy is remembered it will be realised that gone are the days when patients with hepatitis should be subjected to a ritual morning purgation with Epsom salts in order to " stimulate a flow of bile," or should be made to swallow hexamine or salicylate mixtures in an endeavour to " disinfect the biliary tract." A diet of dry toast and skimmed milk is equally unnecessary.

Dogmatically stated the lines to be followed are :—

(i) *Rest :* This is all important. Bed rest must be continued until the urine is bile free ; thereafter the patient may be allowed up, but a return to full activity should not be allowed until all traces of jaundice have disappeared from the skin and sclera.

(ii) *Diet :* For reasons which will be given, the case for gross dietetic restrictions in this illness has not been made out. Most patients, especially in the early stages, will voluntarily put themselves on the lightest of diets and, in particular, will eschew all fats. But many patients will have no anorexia and, indeed, it is common for the appetite to be increased to a pathological degree as recovery sets in. In these cases there is no need for fats and eggs to be restricted and a light diet as nourishing as rationing permits should be given.

(iii) *Bowels :* Daily Epsom salts may do more harm than good. A patient was seen recently who had become dehydrated owing to constant watery motions, produced by daily saline purgation for a period of three weeks. Should the constipation which commonly occurs at the commencement of the illness give rise to symptoms then it is, perhaps, most conveniently relieved by a single saline purge, but in many instances a small enema is much more satisfactory.

(iv) *Pruritus :* This can be most troublesome and large doses of the longer acting barbiturates (*e.g.* Medinal grs. 10) may be required to prevent loss of sleep. Luminal grs. $\frac{1}{2}$ b.d. may give some relief, as does ephedrine grs. $\frac{1}{2}$ in some cases. Anti-pruritic lotions (Menthol grs. $\frac{1}{2}$ in calamine lotion or lotio evaporans (B.P.)) may help. The new drug Benadryl may be a great help.

The severe case.—When the jaundice is deep and prolonged and there are signs of hepatic failure, every proved adjuvant to treatment must be used and in addition substances whose value is still sub-judice may be employed.

Dehydration will call for intravenous glucose saline infusions and in some cases reduction in the plasma proteins will require the use of plasma; whilst whole-blood transfusions should be given if anæmia is marked.

If anorexia is absolute, small doses (up to 15 units) of insulin may be stimulating. The value of the routine use of insulin and glucose in this disease has been disproved by Scandinavian workers.

The sulphur-containing amino acids, methionine and cysteine, about which high hopes were entertained, have not entirely proved themselves. But in the seriously ill it is as well to ensure that the body has ample supplies of them at its disposal and 5 grams of one or the other of them should be given daily.

RECENT WORK ON THE TREATMENT OF HEPATITIS.

An immense amount of work has been done during the war on the effect of feeding various substances to patients with infective hepatitis. The starting point was the observation by American workers that amino-acids, particularly those containing sulphur, such as methionine and cysteine, prevented liver damage when starved dogs were given an overdose of chloroform. Notice the sequence of events :—

Starved dogs + chloroform——> Liver necrosis.

Starved dogs + methionine + chloroform——> Liver health.

In other words, the subjects were starving and the amino-acids were given prior to the infliction of liver damage and so they acted as preventive and not curative measures. In human beings the conditions have been different. So far, our patients have not been starving and the amino-acids have been given after the liver has been damaged. Feeding experiments have been carried out comparing high and low protein diets, high and low fat diets and diets with and without the addition of methionine and cysteine. On the whole the results obtained, when subjected to statistical scrutiny, do not substantiate the claims that the duration of infective hepatitis is inversely proportional to the amount of protein in the diet. There is some evidence that cysteine is helpful in preventing relapses, but none that it can appreciably shorten the disease. Indeed, this should not be expected; these amino-acids are substances which are apparently essential for the health of the liver. By supplying them in excess we do not influence the rate of repair but we do ensure that the necessary raw materials are present in abundant amounts so that recovery may be as complete and as speedy as possible.

SYRINGE-TRANSMITTED HEPATITIS.

At the risk of creating confusion, this picture must be completed by the mention of homologous serum jaundice or, as I prefer to call it, syringe-transmitted hepatitis.

It has been recognised for some time that the transfusion of blood or its derivatives may sometimes be followed at long intervals by the development of jaundice. In some venereal clinics the jaundice rate in those receiving intravenous injections was as high as 40 per cent. and it was shown conclusively that this was due to an icterogenic principle which existed in the blood of some patients and which withstood the ordinary methods of sterilisation and was transmitted from patient to patient in the syringes used. This occurrence has since been described in diabetic clinics, after the use of pentothal

and penicillin and even after the use of syringes for the withdrawal of blood for laboratory purposes.

Though the illness is in many ways indistinguishable from infective hepatitis and the pathology is identical, a knowledge of this type of hepatitis is important because, as a rule, it is more severe and protracted. Deaths which may occur in hepatitis are almost all due to this form.

A comparison between the two may be conveniently given in tabular form thus :—

	Infective Hepatitis	Syringe-Transmitted Hepatitis
Morbid Histology	Central Lobular necrosis	Central Lobular necrosis
History	No syringe within previous six months	Injection, lab. test or blood, etc., transfusion
Incubation period	30 days (20–50)	120 days (60–210)
Duration	Up to 21 days	Over 21 days
Nature	Mild	May be serious
Symptoms	Rashes, joint pains rare	Rashes, joint pains more common
Immunity	No cross-immunity	No cross-immunity

Though the morbid histology is identical, the difference in incubation periods, in prognosis and the absence of any cross-immunity suggests that these are two separate diseases, though in most instances they are clinically indistinguishable.

Tropical Diseases and the Medical Student

By a Village Doctor.

I SEE that there is a proposal to give systematic instruction in tropical diseases to the medical student. Coming at the present time this is most opportune, because for some years to come doctors are certain to be consulted by many patients who contracted diseases when on war service in hot countries.

There are many hundreds of doctors who had the opportunity of serving in the tropics and sub-tropics during the recent war. This gave them an unrivalled first-hand experience of diseases of hot climates and what I may call a colloquial knowledge, which they will find of advantage for the rest

of their lives. It is most important to be familiar with the methods of investigation and with the long-term sequelæ for which patients may seek advice.

Dr. Joad would probably say " Yes ! but it all depends what you mean by ' tropical diseases.' " Let me try in a very general way to answer this question. It is helpful to divide them into three groups.

In the First Group I would include diseases which to-day are almost confined to hot countries but which were once indigenous, endemic and prevalent here in Great Britain. Because they are now mainly prevalent in hot countries we have got into the habit of regarding them as tropical diseases, but *they are not.* They are quite capable of becoming re-established in this country and, given the right conditions, of even flourishing for a time. These diseases are cholera, plague, malaria, dysentery, leprosy, relapsing fever and hookworm.

Malaria and dysentery are not entirely extinct yet in this country. Cases of " ague " still occur in the Fen District, Romney Marsh, and the low-lying country around the estuary of the Thames. There have always been sporadic outbreaks among the civil population in the neighbourhood of garrison towns after the return of troops from operations in malarious countries. These troops form a natural reservoir of the disease from which local anopheline mosquitoes become infected and pass the infection on.

Dysentery of the bacillary type is to-day, and always has been, endemic in almost every rural area in this country. Many hundreds of cases occur every year which are unrecognised, not notified and receive no specific treatment. They are the natural reservoir from which the so-called " asylum " or " institutional " dysentery is recruited. It is almost certainly from these cases that the baffling disease we know as chronic ulcerative colitis arises.

Leprosy was at one time very common in this country. In the fifteenth century there were ninety-five religious hospitals for lepers in Great Britain and fourteen in Ireland. In the 15th century there began a most remarkable and inexplicable decrease which was not due to any specific measures taken against it. It was observed that this decrease coincided with a great increase in the prevalence of syphilis. This was probably *post hoc* rather than *propter hoc* and merely fortuitous ; but it did occur. There is something quite unintelligible about this decrease and ultimate disappearance of leprosy which gives rise to the reasonable suspicion that there are unknown factors governing its epidemiology and geographical distribution. It would be unwise to say that it has been permanently stamped out from Great Britain.

Plague. Although it is unthinkable that there will ever again be an epidemic of the magnitude of that of 1664–1666, localised outbreaks do occur in the dock areas of seaport towns, fortunately of limited extent. They can usually be traced to infected rats from foreign-going ships. The pneumonic form of plague was probably that chiefly concerned in " The Great Plague." This is virulently infectious from man to man without the good offices of the rat and the rat-flea. It is certainly more virulently infectious than measles or scarlet fever. If a local focus of infection were once established I see no reason why it should not spread in epidemic form like measles and scarlet fever.

Cholera has invaded this country several times during the 19th century. " It never travels faster than man can travel." It has an incubation period of one to five days and it would be possible for a person to be infected in the

middle East on Monday and be in London on Tuesday or Wednesday two or three days before he developed the disease, which might give rise to a fulminant outbreak.

Relapsing Fever occurs in Norway, Denmark, Germany, Russia and Turkey. Virulent epidemics have taken place in Central Africa, the Congo, East Africa, Uganda, Abyssinia and Madagascar. It is found in India, Persia and China. Epidemics have occurred in Great Britain and the U.S.A. Its geographical distribution is far too wide for it to be regarded as a " tropical disease."

Hookworm is prevalent in all tropical and sub-tropical countries, but there have been epidemics in Cornish mines.

Typhus is happily extinct in this country now. It was once common and even in fairly recent years cases occurred in Ireland. Lice and Rickettsia can flourish perfectly well in cold countries.

The Second Group of diseases have never spread very far beyond the tropics because they depend for their transmission on vectors which can only flourish in warm countries. If these vectors are accidentally introduced into colder climates they die off quickly. Consequently the diseases in this group have a better claim to the adjective " tropical." The group includes Yellow Fever, African Sleeping Sickness (trypanosomiasis), various forms of Leishmaniasis, Onchocerciasis, Clonorchiasis, Filariasis, Rocky Mountain Fever, Japanese River Fever and certain other varieties of typhus and tick-borne infections.

The Third Group covers diseases which are usually considered as tropical diseases but are in reality much more widely distributed. It includes :—

Undulant Fever, (Malta-, Mediterranean- Abortus-fever) now known to occur not only in Malta and along the Mediterranean littoral but also, under the name Abortus Fever, in this country.

Pellagra, once met with chiefly in Italy and in some of the southern States of the U.S.A. but now known to occur in many other places. Formerly thought to be caused by the consumption of " spoiled maize " (" Zeist " theory) but now known to be due to PP avitaminosis (nicotinic acid). I saw several typical cases of this in England in persons living on the rationed war-time diet which still obtains in peace.

Amœbic dysentery is another member of this group. Although it flourishes in the tropics because of deplorable sanitary conditions and huge numbers of infected natives, it has no specific claim to be considered a tropical disease. It may be contracted anywhere if the parasite or its cysts be ingested.

Sprue is included in this group. Although it is usually confined to hot climates, it may first manifest itself in this country in Europeans who have returned home after long residence in the tropics. They will usually be found to have suffered from dysentery or " hill-diarrhœa." It may develop a few months or even a year or two after return to this country. It resembles, but is quite distinct from cœliac disease, in that there is no hereditary factor.

Other diseases of this group are Alastrim or *variola minor*, tularæmia, a disease of rodents communicable to man and in one of its forms somewhat resembling plague ; and finally, Typhus in one or other of its various forms—true typhus, murine typhus, " Marseilles Fever," scrub typhus (long known as Japanese River Fever) and finally, Flea-typhus or Brill's disease.

A QUESTION OF FORM

It is as well to bear in mind that the " every-day " diseases of this country are almost as common in hot countries as they are here, and often in more exotic form. Typhoid and small-pox are much commoner, and rabies, now fortunately radicated here by the rigid measures in force against it, is an ever-present danger almost everywhere abroad.

I hope that to some extent I have answered the hypothetical Dr. Joad's question.

Correspondence

"Gate Crashers"

SIR,—The President of the United Hospitals Rugby Football Club has recently made an appeal for better behaviour at Inter Hospital Cup Tie matches. On several occasions supporters have "gate crashed" into the Richmond Athletic Ground avoiding payment by climbing the walls, and there have been unpleasant incidents with ground staff and police.

The President stresses that if such behaviour continues, difficulties with regard to the lease of this ground for Hospital matches, are likely to be raised and may also result in unpleasant police action being taken.

Yours, etc.,

G. D. CHANNELL,
Hon. Sec. Clubs' Union.

Guy's Hospital, S.E.1.

Sport

BOXING

Those who were fortunate enough to be present at Seymour Hall on March 5th were rewarded by an exceedingly enjoyable evening's sport. The treacherous weather naturally affected the attendance but Guy's Amateur Boxing Club can feel satisfied of their first open tournament, the proceeds of which will pass to the funds of the Hospital.

The main feature of the programme was a special team match of seven bouts between St. Mary's and Guy's, and the excitement was intense when the referee was called upon four times to give a casting vote.

On the whole St. Mary's gave the impression that they were fitter and had trained hard, appearing to last the three rounds better than some of Guy's representatives.

RESULTS: ST. MARY'S *v.* GUY'S.

Lightweight.—P. Guelpke (St. Mary's) defeated M. M. Mason (Guy's) in the first bout of the series on points. St. Mary's deserved this success as Guelpke was quicker to the punch and Mason found it very difficult to overcome his opponent's constant ducking. The Guy's boxer did extremely well, however, when leading off and landing his blows from long range.

Welterweights.—F. G. Ellis (Guy's) levelled the score with a good points verdict over R. Cooper (St. Mary's). Ellis put up a good show and by his efforts to lead off and get his punches in before his opponent he built up a useful lead in spite of Cooper's persistent attacks.

S. F. A. Westgate (Guy's), captain of the club, appeared to win his bout with K. Manley (St. Mary's) with ease, but the judges disagreed and the referee's casting vote went to Westgate. This bout was interesting to watch as both boxers attacked in turn and scored with good hits with either hand but Manley, who had a longer reach, could not quite cope with Westgate's two-handed punching.

Light-Heavyweights.—Another casting vote gave the verdict to R. D. Walsh (Guy's) over J. Hurrell (St. Mary's). Walsh was given a hard battle and tired towards the end, but he had boxed with judgment by waiting to pick his blows at the right moment and he got himself out of frequent difficulties by good covering up when Hurrell attacked. G. Bradford (St. Mary's) was another winner by a casting vote, but his opponent, A. Du Plessis (Guy's), put up a magnificent performance and this was undoubtedly the best bout of the series. Du Plessis

was full of action, carefully working himself into position for attack and landing many telling blows which must have surprised Bradford who was floored twice during the contest. Bradford, however, avoided many blows by ducking which seemed to disturb Du Plessis, and he proceeded to score points with some clean hitting when straightening up.

Heavyweights.—The high light of the evening came when bearded B. Eksteen (Guy's) entered the ring to meet a similarly adorned D. Miller (St. Mary's) Eksteen was given the verdict on the referee's casting vote, but few would have been surprised had it gone the other way. Every ounce of energy rather than skill was introduced and both were so fatigued towards the finish that their gladiatorial entry into the ring ended with both boxers swaying hither and thither endeavouring to land blows with featherlike strength. Congratulations to both for a grand sporting contest.

The biggest surprise of the evening was the defeat of B. W. Cole (Guy's) by J. Ambrose (St. Mary's) in the third round. Cole had built up a good lead with some splendid two-handed attacks, but Ambrose made use of his heavier weight by countering powerfully to beat off Cole's obvious attempts for a quick finish. In the third round, Ambrose forced Cole to retreat and immediately shot over a right hand punch to the jaw which floored Cole, who would probably have risen had he not struck the back of his head heavily on the canvas. Nevertheless, Ambrose took full advantage of his limited opportunities to land and no doubt Cole paid the penalty of not training for the event.

The special contests were thoroughly appreciated and full of skilful boxing. The results were :—

H. Seymour (Old Goldsmith's B.C.), South Eastern Divisional Finalist, beat C. Linsell (Lynn A.C.), National A. T. C. Champion 1945, on the referee's casting vote over four three-minute rounds.

W. Gair (Royal Ordnance Factories), Civil Service Champion, beat F. Innis (Harrow and Rugby B.C.), London Federation of Boys Champion 1946, on points. K. Ryan (Langham B.C.), Finalist British Junior Championships 1946, beat A/C. A. C. Mackie (Lynn A.C.), London A.T.C. Finalist, on points. A. Moore (Stansfield, Oxford and Bermondsey) beat J. Bridgman (Deptford Sea Cadets), in the third round.

It is not usual for hospitals' boxers to enter for open competitions but as Guy's was the promoting club it entered J. E. Jones in the 9st. 9lbs. Novices and he won it. In the first series Jones stopped T. J. Tanswell (Harrow and Rugby) in the first round, and Gunner W. Forbes (Royal Artillery) beat P. Roberts (Royal Ordnance Factories) on points. In the final, J. E. Jones boxed very cleverly and hit harder than his opponent. There was much spoiling on the part of both, but Jones scored at frequent intervals to earn a points decision. Both boxers were over cautious and their tactics to some extent indicated a lack of resolution.

The series of contests went in favour of Guy's by 4 bouts to 3, but what must have impressed everybody was the fine spirit of sportsmanship shown by the respective representatives from these two great rival hospitals, and this also applied to the contestants in the special bouts between well-known boxers from prominent Amateur Boxing Clubs. Altogether, a grand evening and a friendly atmosphere.

Hospital Information, etc.

NOTICES

DEPARTMENT OF SURGERY.

On Tuesday, March 18th, at mid-day, there will be a further demonstration in the series of operative procedures in Theatre II.

On Saturday, March 22nd, at 10.30 a.m., there will be a Clinico-Pathological meeting in the Anatomy Theatre.

H. J. B. ATKINS,
Director of the Surgical Department.

BIRTHS

BUTTERFIELD.—On March 4th, 1947, at Tiverton and District Hospital, Devon, to Jean (née McGahey), wife of Fred Butterfield, L.D.S., Eng.—a daughter (Joan).

MARRIAGES

ESMONDE—FAIRMANER.—On February 6th, 1947, at St. John's, Gravesend, Lieut. (E.) Roderic Anthony Esmonde, R.I.N., to Celia June Fairmaner, S.R.N.

DEATHS

GREEN.—On March 6th, 1947, Thomas James Green, L.D.S., R.C.S., of Alwick, Sussex.

STEWART.—On March 6th, 1947, Walter Grahame Stewart, M.B.E., M.B., B.S., of Ware, aged 72 years.

Eds. { D.H.F. H.A.R.

GUY'S HOSPITAL GAZETTE

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PASSIM

A SHORT while ago, at a Brains Trust meeting held at this hospital, a question arose about the value of lectures to the student. One authority expressed the opinion that far more knowledge could be acquired from listening to a really good lecturer for an hour than from a similar period of time spent reading. This statement provoked disagreement from a second "brain" who maintained that lectures were, from the point of view of learning, almost useless and certainly were completely dispensable.

An interesting lecturer can undoubtedly teach a great deal in a comparatively short length of time and, apart from any unprinted tit-bits of knowledge that may be expounded to his audience, the method of instruction is enjoyable both for its own sake and also for the fact that, to the student, the well-spoken word is a welcome change from the printed page of the text-book.

The qualities of a good lecturer have been variously described, but perhaps one of the most necessary attributes is that he shall be able to prevent the members of his audience from falling asleep. This he ought to accomplish by sheer weight of personality (whatever that means) and should not have to resort to direct caustic comment. This, on first consideration, may not seem an unduly difficult task but so often this noble aim is frustrated purely on account of prevailing physical and atmospheric conditions.

As an example, one may consider a typical Clinical Lecture at Guy's.

To hold such a meeting at one o'clock in the afternoon is courting disaster, for the unfortunate student, weary from queueing for lunch outside the College, exasperated from trying to get food when he ultimately gets to a table, and hungry when he has eaten it, is not in the pinkest of conditions and is a customer who will be hard to please and even harder to keep conscious. The heavy atmosphere of the Anatomy Theatre, pregnant with the stale smell of humanity, acts an immediate soporific, dulling the intellect even before the lecturer has had a chance to sharpen it.

The arrival of the great teacher, amidst a clamour of banging, stamping, clapping, and crashing of seats, has a transitory effect and succeeds in securing all-round attention for the customary polite introduction, "Gentlemen . . ," which may or may not be true. If all goes well which, as already explained, is generally the case with a star performer, this interest is maintained and the words of wisdom are not only heard but absorbed by the eager listener. Unfortunately, however, such conditions seldom prevail for very long as, sooner or later, comes that ill-fated remark: "Right now, I'll have the first slide, please Ireland," whereupon, with a decisive click, the whole theatre is plunged into sleepy shadow. When this happens the lecture is often virtually at an end. Warning of this unhappy event has, of course, already been given by the usual series of hissings and explosions from that great and amazing

apparatus which nestles in the centre of the theatre, like some great monster chained in a pit.

Nevertheless the dim lighting brings with it all the dread symptoms—a general lack of muscular tone, bilateral ptosis, and, in rapidly progressive cases, queer, sharp, flexion and extension movements at the atlanto-occipital joint, and increasing dimness of vision.

" . . . A drowsy numbness pains
My sense, as though of hemlock I had drunk,
Or emptied some dull opiate to the drains
One minute past, and lethe-wards had sunk,"

wrote John Keats on hearing the song of the nightingale but, being an old Guy's man, he may have experienced similar emotions for less romantic reasons.

With such conditions as these it is exceedingly difficult to uphold a state of attentive wakefulness and the slightest lull in stimulus will result in an increasing number of slumped forms and drooping heads. Naturally there are some persons who find it impossible to sleep out of hours, while others spend their entire day in a state of partial coma, ready to slip into slumber at a moment's notice. The majority of individuals, however, only succumb when circumstances are particularly ill-adapted for conscious approval. To ensure the mental alertness of these persons need not be an insuperable task and the lecturer, by dint of personality and verbal ability, coupled with an efficient ventilating system in the lecture theatre, should be rewarded with an appreciable degree of success, while his audience will have drunk deep of the Pierian spring instead of merely languishing away so many forgotten moments in the arms of Morpheus.

WITH much disapproval we observe that the door to the Pathology Department Library bears a notice informing the world that the sanctity of its confines is reserved for ex-service and qualified men. Disregarding the ambiguity of this inscription, which would seem to imply that the Pathology Department has thrown open its portals to the whole of the British Legion, the exclusion of persons not yet conforming to these categories is hardly a public-spirited move. May not the meagre, non-commissioned, civilian student, as well as his battle-weary comrade, enjoy the pleasures of silence, study, and tobacco all at the same time?

WE congratulate W. Vans Agnew who has been selected to play Hockey for Scotland against Wales on March 29th.

A GIRL walked up to the information desk in an American hospital and asked to see the upterne.

" I think you mean interne, don't you, Miss ? " asked the nurse on duty.

" Yes, I guess so," said the girl, " I want a contamination."

" You mean examination, don't you ? " corrected the nurse.

" Well, I want to go to a Fraternity Ward, anyway," the girl said.

" I am sure you mean Maternity Ward, my dear," the nurse answered, to which the girl replied loudly :—

" Upterne, interne, contamination, examination, fraternity, maternity, what the hell's the difference ? All I know is that I haven't demonstrated for two months and I think I'm stagnant."

—*University of Sydney Medical Journal*).

Nerve Injuries Affecting the Hand

A Clinical Lecture delivered by NILS L. ECKHOFF, on July 18th, 1946.

THE diagnosis of a simple nerve injury in the hand seems to puzzle the vast majority of students. Such a lesion is of immense importance to the patient for the fate of the hand as a useful member may depend upon it. Nor is it of lesser importance to the student, for his fate in the examination hall may likewise depend upon it. I hope to be able to clarify some of the problems for you. I shall not be able to devote time to a detailed description of the Brachial plexus with which you should be familiar, but will remind you for the moment of the peripheral distribution of the median, ulnar, and radial nerves, or rather the changes that will be seen in the hand as a result of section of these nerves. If such changes are present, it will of course be necessary to study the arm and forearm up to the supposed point of section.

In *median palsy* there will be paralysis followed by wasting of the muscles of the thenar eminence, and the first two lumbricals. Anæsthesia (somewhat variable) of the volar aspect of the thumb, index, middle, and half the ring finger, and of the dorsal aspect of the distal, phalanx of those fingers. It is clear that anæsthesia of the tips of the thumb, index and middle fingers deprives the hand of all its finer usefulness. The best single motor test in my opinion is the power of the abductor pollicis brevis. This is investigated by placing the two hands palms uppermost, thumb in front of the index metacarpal, and asking the patient to "point to the ceiling." The muscle belly of the short abductor if functioning can be seen and felt to contract when this is done. It is difficult to distinguish between flexion and opposition, so that the test for the opponens is, of its own accord, not so reliable. It should, however, be done in addition.

Ulnar palsy produces paralysis of the hypothenar muscles, the third and fourth lumbrical, all the interossei, and the adductor of the thumb. There is anæsthesia, fairly consistently marked, of the volar and dorsal aspects of the little finger and ulnar side of the ring finger. Wasting of the muscles mentioned is easily detected—especially in the first intermetacarpal space. Motor power is tested by abduction and adduction of the fingers (interossei), adduction of the thumb (adductor pollicis) and by extension of the fingers with the metacarpo-phalangeal joints held flexed (interossei and lumbricals).

The hand tends to become clawed from loss of this particular movement, and a special splint is used to prevent this.

Combined ulnar and median lesions are seen, but the completely flattened and ape-like claw hand is more often due to a lesion of the medial cord of the plexus (T.1.) or of the cervical cord (as in syringomyelia).

Radial palsy produces paralysis of the long extensors of the fingers (and wrist) but only a small area of anæsthesia on the dorsum, between the thumb and index metacarpals. The difference between the area of complete anæsthesia and the full anatomical distribution of the nerve is due to overlap by the other nerves.

In addition to inspection of the hand, and tests for motor function and anæsthesia to cotton wool, it is important to record accurately the loss to pinprick (analgesia) and the loss of sweating (anhidrosis).

It is convenient to mark the anæsthesia with a continuous line of Indian ink, analgesia with a dotted line, then dust the hand with the following powder :

Sodium chinizarin 2–6 disulphonate	28 gr.
Anhydrous sodium bicarbonate	24 gr.
Rice starch	48 gr.

and induce sweating by giving the patient aspirin grs. 10, a cup of hot tea and a radiant heat bath. The anhidrotic area remains pale while the normal area becomes reddish purple. The hand is then photographed for record purposes. The area of loss of sweating corresponds fairly accurately with the area of anæsthesia, whilst the area of analgesia is somewhat smaller.

It is not as a rule necessary to test deep pressure and pressure pain, nor tactile localisation, twopoint discrimination or stereognosis except in incomplete or recovering lesions.

" Protopathic " and " epicritic " sensation are no longer regarded of any significance.

It has already been noted that the area of complete sensory loss is less than the anatomical distribution of the nerve ; this is due to overlap for some of the sense organs derive nerve filaments from adjacent nerves. The area of loss varies in different individuals, and in the two hands of one individual. There is, furthermore, a shrinkage in the area of anæsthesia within a few days of the injury due to (1) the awakening of sensibility in nerve endings having this second supply (2) ingrowth of fibres from adjacent nerves and (3) recovery in adjacent nerves from transient block.

We have so far been considering complete division. Partial lesions may of course occur. There may also be a lesion in continuity, or a transient block. The Oxford School have introduced the following terms which are being used in the literature—it is wise to be aware of them :—

Division (complete or partial)	neurotmesis.
Lesion in continuity	axonotmesis.
Transient block	neurapraxia.

Following division or lesion in continuity Wallerian degeneration occurs but not in transient block. Different nerves in the same limb may suffer different degrees of injury. Diagnosis may therefore become exceedingly involved, and close and repeated observation will alone discover the true extent of the damage. There are further difficulties. In some hands the thenar muscles are supplied by the ulnar nerve (determined by faradic stimulation over the nerve trunk or procaine block). In others the patient may learn trick movements, in an attempt to compensate for the disability (but not to trick the examiner).

I do not tell you all these things in order to make diagnosis sound impossible, but rather to stimulate you to think deeply about and investigate most carefully any individual case. However, do not jump to the conclusion—if you are puzzled—that the anatomy is abnormal, or that the patient is trying to trick you, it may have something to do with the complexity of the injury.

Treatment.

For civilian injuries, provided the case is seen within the first few hours, and complete asepsis can be secured, immediate suture is the treatment of

choice. If the nerve is disturbed as little as possible and it can be brought together, without tension and without rotation, with fine unabsorbable sutures, an excellent result can be expected.

In civilian injuries seen late, or war injuries, it is extremely doubtful if immediate suture has any place. As in tendon injuries the smallest degree of infection spells disaster. One has only to think of the complicated process of repair to understand this.

The fibres in a mixed nerve are myelinated and unmyelinated, and may be motor, sensory, vasomotor, secretory, etc. Each sensation—pain touch, cold and warmth, has its own fibre and its own nerve ending. There is a very complicated intraneural pattern, even an intraneural plexus. It is indeed a miracle that any fibre ever finds its way to a suitable end organ. This can happen to a high degree of perfection if suturing is perfect, and scarring minimal. (Fibrin " glue " has been used experimentally for nerve suture, but it is too early to say if it will be really satisfactory). Infection produces massive scarring, and it is then well nigh impossible for new fibres to find their way into the distal stump. Instead they grow and branch, turn back on themselves and grow forward again, thus producing a mass of nerve fibres and scar tissue, commonly called a " neuroma."

It is therefore considered better if the slightest infection is anticipated to make no attempt to suture the nerve, but at the most mark the cut ends with a piece of black suture material for later easy recognition, and make plans for later secondary suture.

Secondary suture must be performed within a reasonable time, say eight weeks, after all infection has subsided lest the end organs and muscles be irreversibly replaced by fibrous tissue. If nerve, tendons and bone be injured, priority should often be given to the nerve when repair is planned. It may, however, be necessary to provide a flap to replace scar tissue first. At secondary suture the " neuroma " of the proximal stump must be removed with a sharp razor blade, and the nerve cut back till normal nerve bundles are seen. Likewise the thickening of the distal stump, the " glioma," must be pared away. The nerve ends must be brought together with extreme accuracy, avoiding catgut, or stitches through the nerve itself. If a gap is present, the nerve may be mobilised, neighbouring joints flexed—or even a graft inserted. Some surgeons prefer a " cable graft " made up of many small nerves held together, rather than a single thicker graft. As the results of grafting are never so good as in direct approximation—it is a little difficult to be certain that one is better than the other. Some hold that suture in flexion to reduce a gap is of little value, for the subsequent stretching of the nerve produces fibrosis to such a degree as to nullify the advantage of the gap closure. Nevertheless, some attempt must certainly be made to bring about repair of a divided nerve, for lack of regeneration is equivalent to loss of function of the hand or finger.

Degeneration and Regeneration.

Complete Wallerian degeneration occurs in complete division or complete lesion in continuity. The axons in the distal end die and disappear. The myelin sheath is broken up into droplets and the nuclei of the neurilemma multiply. The proliferation of the " Schwann cells " is marked at the site of division, producing the " glioma " above-mentioned, but the rest of the nerve diminishes in size.

In the proximal end there is some retrograde degeneration and chromatolysis of the cell body. At the same time axons grow out from the cut end, and sprout, in their endeavour to find the distal end. Those that fail, or are barred by fibrous tissue, form complicated spirals. The whole is an end bulb or "neuroma." A few fibres growing through to the distal end may give Tinel's Sign. This is one of the reasons why this sign is considered unreliable in prognosis.

Some fibres may grow into the skin scar, producing pain on the slightest touch.

In traction lesions (*e.g.* brachial plexus lesions) extensive fibrosis may occur up to a distance of 15 c.m.

In ischæmic lesions there is extensive collaginisation of the nerve.

During this period of degeneration extensive changes occur in the nerve endings, muscles, skin, blood vessels, sweat glands, subcutaneous tissues, end organs, joints and bones. Some may be due to trophic influences, some to disuse, but are ultimately irreversible. Hence the importance of suture before this has happened.

The electrical reactions below the injury are as follows: After 10–14 days percutaneous faradism produces no response, but there is a sluggish response to galvanism, which may be brisk if the limb is warm. The difference between A.C.C. and K.C.C. is not considered important. If there is no response to faradism or galvanism, the muscle is fibrosed. Bipolar stimulation directly over the nerve is valuable in telling if there are any nerve fibres active.

Vaso-dilatation follows division of a mixed nerve, but after a few weeks the temperature is lower than the normal limb. Later vasomotor reactions are abolished in complete injuries.

The axons that have successfully penetrated through to the distal end proceed to grow down the nerve at the rate of about 1–3 m.m. a day. But there is some delay in penetrating the scar and further delay in regeneration of the end organs. Motor end plates degenerate in about six months. Old end plates may be reformed, and new ones may possibly be laid down.

Tinel's sign (tapping the nerve below the lesion produces tingling in the peripheral distribution) is considered unreliable. After nerve suture it has some value as a measure of progress, if found to be advancing.

Treatment.

Massage.—Deep massage over a paralysed muscle can only do harm. Light effleurage may be permitted to maintain mobility of the muscle fibres.

Galvanism.—There is considerable difference of opinion over the value of galvanic stimulation. Some maintain that it is harmful—others that it diminishes muscle wasting and aids recovery. I think most people prescribe it. Patients certainly think it is doing them good, when they can see the muscle contracting.

Splinting.—All are agreed that it is paramount to support paralysed muscles to keep them from being stretched. Splints are designed for each type of palsy. For ulnar palsy the metacarpo-phalangeal joints must be kept flexed, to prevent harmful stretching of the intrinsics. For median palsy the thumb is held in front of the index metacarpal, well abducted, to relax the opponens

and short abductor. For radial palsy the wrist and metacarpo-phalangeal joints should be held in extension—but *not* the interphalangeal joints. The old fish server cock-up splint is an abomination, and I can think of no condition in which it is required. In radial palsy—or in burns—one has seen far too many hands ruined by keeping the fingers in extension where they so rapidly get stiff, for which there is practically no cure.

By the same token let me remind you that the application of a splint does not indicate immobilisation. Far from it. The joints must be put through their full range twice a day. Better still, it is possible with all these splints to arrange for elastic reaction to take the place of, and act like, the palsied muscles. This not only keeps the joints moving, but gives the antagonists something to work against.

Occupational therapy.

Occupational therapy is designed specially for each type of palsy, and can well be executed with the splints in position.

Prognosis.

In transient block (*e.g.* crutch palsy and tourniquet paralysis) recovery may be exceedingly rapid—if somewhat patchy, although in a series of 14 cases of tourniquet palsy I investigated in 1931, recovery was delayed in most for three months, indicating a lesion in continuity. (*Lancet* 1931, **2**, 343).

In lesions in continuity or sutured nerves, axons have to grow out from the upper end. I have indicated that although the growth along the nerve may be at the rate of 1–3 m.m. per day, there is delay at the point of damage and at the end organ. In mixed nerves the recovery is worse than in pure motor or sensory nerves, and the intrinsic muscles of the hand are the last to recover. In digital sensory nerves recovery is good, and these must always be sutured, even if a graft is needed, for anæsthesia of a finger is a great handicap.

A Case of Neurofibroma of the Stomach

By A. M. HUNTLEY, M.R.C.S.

BENIGN tumours of the stomach are a clinical rarity, although their incidence varies according to whether the series was compiled from post-mortem, surgical, or radiological studies.

Rigler and Erickson (1) report that they constituted 26 per cent. of gastric neoplasms in 6,742 autopsies. Of this 26 per cent. leiomyomas accounted for the majority (60 per cent.), and most of these were too small to give rise to symptoms during life.

Eusterman and Senty (2) reviewing 2,168 cases of gastric neoplasms requiring surgical treatment, reported 27 benign tumours or 1.3 per cent.

Finesilver (3) reports that in 43,000 radiological examinations of the stomach there were 6 benign tumours to 394 carcinomas. A ratio of 1 to 66.

Benign tumours usually give rise to symptoms due to their complications, the most frequent being hæmorrhage, and thus presenting as a hæmatemesis.

They may also present as pyloric obstruction, which is typically intermittent, and, more rarely, from gastric dysfunction due to their size alone.

Malignant degeneration does occur but statistics about this vary widely. Lahey and Colcock (4) report that of 7 benign tumours removed, 5 showed sarcomatous degeneration., whereas Judd and Horner (5) state that of 50 cases malignant change was found in only 2.

Clinically they are difficult or impossible to differentiate from malignant tumours, especially as a fractional test meal often shows an achlorhydria with blood in the specimens. The diagnosis will rest almost entirely upon the radiological appearances. Golden and Stout (6) suggest that the following findings are strongly indicative of benign tumours :—

1. A central or marginal defect, usually rounded and smooth, and occasionally exhibiting a crater shadow in the dome.
2. No contraction or spasm of the stomach.
3. Peristalsis is uninterrupted, and the stomach wall remains pliant.
4. The rugæ are not obliterated as in a carcinoma, or thrown into convergent folds as in an ulcer.

The following case is of interest in that it exhibited the characteristics already outlined, but histological examination showed it to be a neurofibroma, which is of extreme rarity.

History.

Miss G, aged 47 years.

Complained of feeling tired and run-down for some months. Three weeks prior to admission she had vomited about half a cupful of reddish-brown fluid. Since then she complained of epigastric pain. This was situated below the left costal margin, and brought on by standing upright. The pain was of an aching character and showed no radiation, and was relieved by lying down.

Fig. I.

Fig. II.

Previous diseases.

No relevant past diseases. She had never suffered from indigestion, and had always been able to eat all foods.

Appetite.—Good.

Bowels.—Normal. No recent change in the colour of the stools.

Weight.—No loss.

On examination.

A thin woman. Mucous membranes pale.

Nails—normal.

No palpable lymph glands. No evidence of neurofibromata on body.

Abdomen.—Tender in the epigastrium from beneath the left costal margin to the region of the umbilicus.

No tumour was palpable.

Investigations.

Red cell count—3.8 million. Hæmoglobin—58 per cent.

White and Differential counts—normal.

Blood sedimentation rate—10 m.m. in 1 hour.

W.R. and Kahn—negative.

Fractional test meal—normal.

Barium meal. Figs. I and II.

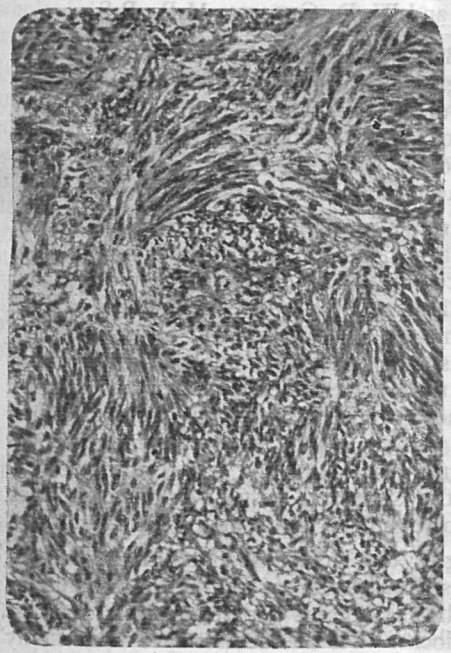

Fig. III.

This showed a large mass arising from the lesser curvature towards the cardiac end of the stomach. It had a narrow base and a regular, smooth, oval outline. The rugæ over the tumour had disappeared but elsewhere were normal.

Laparotomy.

A tumour the size of a small orange was felt through the stomach wall. There appeared to be no infiltration and no secondary deposits in the abdomen.

On opening the stomach the tumour appeared to arise from the muscular coat. The mucous membrane over it was perfectly smooth, with a small area of degeneration. The tumour was freely mobile, and was removed by simple excision.

The patient made an uneventful recovery and was discharged on the 21st day. A follow-up examination four months later showed no abnormality of the stomach and she was symptom free.

Microscopic appearance. Fig. III.

The tumour is well encapsulated and the mucosa of the stomach wall is stretched over it. There are some areas of hæmorrhage, especially round the margin of the growth. The cells are long and slender with spindle-shaped nuclei, and the arrangement is that of interlacing strands and whorls. A palisade arrangement characteristically seen in neurofibromata is a typical feature in these sections.

The tumour would appear to be quite benign.

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My thanks are due to Dr. G. F. Stones, who removed the tumour, for permission to publish this case; to Dr. C. Reynolds for the X-Rays, to Dr. N. Richardson for the histology and the microphotograph, and to Dr. R. Bolton for his help and advice.

A Congress at Strasbourg

By F. L. JACKSON, M.B., B.S., and W. D. GURASSA, M.B., B.S.

BY the kindness of Professor Barré and Professor Redslob, we were invited to attend the 13th Congress of the French Oto-Neuro-Ophthalmological Association at Strasbourg. This took place in October, 1946. Professor Barré is one of the founders of the Association and Professor Redslob was President of the Congress. A joyful atmosphere pervaded throughout the proceedings as this was the first meeting in Strasbourg since the war.

At the end of a long and uncomfortable journey we arrived in Strasbourg before daybreak. We were cold and tired, and the dim outlines of buildings failed to rouse our enthusiasm. A cup of ersatz coffee did not dispel our gloom. Our burdens were soon to be lightened, for as the sun rose, the cobbled mediæval city was revealed to us, damaged by war, but still beautiful. The mighty cathedral, symbol of Alsace, stands practically intact and dominates the scene. From the heights of the tower, we looked out over the crooked streets and chimney pots, the latter now bereft of storks, for the roar of the traffic has scared off those peaceful visitors. On the one hand rose the Vosges, on the other we could see across the Rhine the grim outlines of the Black Forest. The famous clock in the Cathedral is still working, and each day at noon an eager crowd collects to watch the antics of the little figures.

The Civil Hospital of Strasbourg is the largest hospital in France. It covers a wide area and is completely surrounded by a wall. The inhabitants proudly refer to it as "a city in itself." Different departments of Medicine and Surgery are housed in separate blocks. On this occasion we visited only the Neurological Clinic of Professor Barré. We were impressed by the scrupulously clean buildings and by the enthusiastic co-operation of the staff.

We attended some of the Professor's teaching sessions. The method of approach to cases was explained to us, and we examined some of the cases ourselves. Professor Barré is a worthy representative of the great clinical tradition of which France is so proud, meticulously careful in the analysis of signs and symptoms, gentle and thorough in clinical examination. He is especially interested in vestibular function, on which he has written several papers. Tests of this function are extensively used at the clinic, and elaborate schemes for the analysis of results have been devised. Other special fields of interest at the clinic are the so-called " Neuro-Vegetative Crises " and the phenomena of epilepsy. Barré's name is perhaps most often heard in this country in connection with the Syndrome of Guillain-Barré, a form of acute infective polyneuritis.

The main subject at the Congress was presented by Professor Riser, of Toulouse. It was " Les Manifestations Oto-Neuro-Ophthalmologique dans les Hypertensions Artérielles Malignes." This was followed by other papers by those with specialised knowledge of various aspects of the subject. Considerable emphasis was laid on the possible role of the suprarenals in the pathogenesis of Malignant Hypertension, and on the surgical treatment of the condition.

There were other aspects of the meetings. One facetious young female French doctor told us that she had come chiefly to see the hats worn by the Professors' wives and daughters. We replied that we had come to see the Professors' beards, of which we expected a distinguished collection. There were two great non-medical events during the week, a Banquet and, on the last day, a motor coach drive through the Vosges with a visit to the castle of Haut Königsberg. These added balance to the proceedings so that if the whole did not attain the Greek ideal of moderation in all things, at least there was as much of one thing as of another.

In our opinion, Congresses can be very valuable. At a Congress there are opportunities to see, hear and even to talk with the leaders in our own and allied professions. New friends are made, fresh towns and countrysides seen. Kindness and generosity are frequently met, their reverse but rarely. In medicine, as in many other callings, a strong international friendship is desirable, and we must stop at no frontiers. If we achieve a unity in this way, we shall have made a small contribution to that understanding between Nations which is essential for Man's continued peaceful existence.

In closing, we extend our thanks to Professor Barré and Professor Redslob for making our visit possible, and to the staff of the Neurological Clinic for their many kindnesses.

Correspondence

Treatment of Migraine with Urea

SIR,—Some months ago a patient with severe migraine syndrome was sent to hospital for a urea concentration test. It was found that the administration of large amounts of urea " cured " his migraine.

Because the incidence of migraine is on the increase, and there has heretofore been no cure, I seized on the incident as a possible godsend.

Since then I have treated forty cases of severe and intractable migraine with urea, grs. XX t.i.d. for 2 weeks, grs. X t.i.d. for 4 weeks, grs. X b.d. for 4 weeks. In every case symptoms immediately ceased and no case has, as yet, suffered any relapse.

Can any of your experts tell me whether this is entirely empirical—one cannot surely say it is fortuitous—or not?

If it is not empirical, as would appear, there must be some demonstrable logic in this action. It would be most interesting to learn why and how the drug—which is cheap and common enough—produces a cure which is so dramatic and complete.

Whether or not the rationale can be worked out, it's complete and, so far in my practice, 100 per cent. success is well worth knowing.

I am, etc.,

G. B. KIRKLAND.

107, High Road,
Loughton.

Hospital Information, etc.

NOTICES

APPOINTMENTS VACANT.

Applications are invited from Registered Medical Practitioners for the appointment of Chief Clinical Assistant and Registrar (B.1.) (part-time) in the Department for Nervous Diseases at Guy's Hospital. The appointment is until 30th September, 1947, in the first instance, salary £200. Forms of application may be obtained from the Dean, Guy's Hospital Medical School, to whom applications, together with the names of three referees, should be forwarded not later than 14th April, 1947. In October a Registrar will probably be appointed for the usual period of two years in the first instance and the holder of the appointment will be eligible to apply.

DEPARTMENT OF SURGERY.

The current exhibition in the Gordon Museum illustrates the surgery of hæmaturia and will be on show until the middle of April.

On Tuesday, April 1st at mid-day, there will be a further demonstration in the series of operative procedures in Theatre II.

On Saturday, April 12th at 10.0 a.m., Sir Heneage Ogilvie will be conducting a departmental round in Queen Ward.

H. J. B. ATKINS,
Director of the Surgical Department.

PASS LIST

CONJOINT BOARD.

March, 1947.

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ROYAL COLLEGE OF SURGEONS OF ENGLAND

FINAL EXAMINATION.
L.D.S.
February, 1947.

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UNIVERSITY OF CAMBRIDGE.

EXAMINATION IN PHARMACOLOGY FOR MEDICAL AND SURGICAL DEGREES.
March, 1947.

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M. Hatton	M. Rayne

UNIVERSITY OF CAMBRIDGE.

The degrees of Bachelor of Medicine and Surgery have been conferred by proxy on A. P. Baker and T. C. L. Parry.

CHANGE OF ADDRESS

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L. G. C. Martin, M.B., B.S., Devonshire Royal Hospital, Buxton. (Tel.: 1257.)

Denis Malone, O.B.E., L.D.S., R.C.S., Revenue House, 7, Poultry, E.C.2. (Tel.: Central 7070.)

THE SERVICES

AWARD.

Air Commodore R. R. MacKenzie, R.A.F.V.R., has been awarded the King Haakon VII Freedom Medal.

HONOURS.

Professor John A. Ryle received the Honorary Doctorate of Science from McGill University, Montreal, at Oxford, on March 11th, 1947.

BIRTHS

JONES.—On March 21st, 1947, at the Middlesex Maternity Hospital, Bushey Heath, to Esmé (née Davies), wife of Peredur Jones, Capt. A.D. Corps.—a daughter (Andrea).

WOOLSTONE.—On March 17th, 1947, at Harvey Lodge, Harvey Lane, Norwich, to Patricia (née Saxton), wife of A. S. Woolstone, M.R.C.S., L.R.C.P.—a son.

MARRIAGE

REID—GARRETT.—On Saturday, March 15th, 1947, at St. Lawrence's, Edgware, Surgeon-Lt. (D.) D. J. Reid, R.N.V.R., to Margaret Garrett, M.C.S.P., of Edgware.

Eds. {D.H.F. H.A.R.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

AT time of writing it is Easter. A moment ago it stopped raining for a minute and the sun shone for a second. After the winter we have had that in itself almost makes it a fine week-end. One hardly dares to hope that perhaps a few people in some shady nook somewhere may, just for a moment, have doffed their overcoats and merely swung their arms to keep themselves warm.

The Hospital is relatively deserted. Yesterday and the day before many weary individuals could have been seen trudging out through the colonnade, scoliotic from the weight of their suit-cases—weighed down we must add, not with Easter eggs and glad-rags for a sporting week-end, but with text-books, cram-books, notebooks and journals. On their faces they wore the expressions of men determined to avert impending disaster. A last minute sprint for the various examination stakes was their intention. Full of sympathy we trust that they covered the ground that they prescribed for themselves. At least, to date anyway, there can have been little temptation to extend the neck and the knee-joint and bask in the sun.

A WEEK ago a little girl came up to the assistant editor in the Park and said: "I've got bad news for you. We are leaving tomorrow." She was the daughter of the family in our midst—the Warden's daughter, aged nearly six. And how right she was. I hope she enjoys the country, because we shall miss her.

Dr. Bishop was appointed Warden of the College in January, 1938, and he left last week. That is a long sojourn in the Borough. In the war years he was deputy superintendant. It was not a conspicuous appointment, but anyone who was a Houseman at the time will know how arduous it was, how fraught with difficult decisions. We were a happy family at Guy's during the Blitzes. Nerves were on edge, nights were spent in watching and sleep was short. It was no time for being the happiest of families. But we were. There are some people who always bid you good-day. They may not know who you are, but they recognise you as part of the establishment. It adds to the joy of living, and it doesn't cost a sou. The Bishops, all four of them, are such, and we shall miss them enormously.

Our new Warden is Dr. Charles Baker. He needs no introduction. We hope that he will be happy in his new home and extend to him a warm welcome from all collegians.

THE second of Mr. Hanslip Fletcher's drawings of the Hospital appears on another page. Copies may be obtained from the *Gazette* Office, price 3*s.* 6*d.* each, post 6*d.* extra. There are still a few copies of his drawing of the Park for sale at the same price.

WE apologise for a regrettable error in our last issue. It was, of course, Air Commodore R. R. Macintosh, R.A.F.V.R., who received the King Haakon VII Freedom Medal and not, as printed, R. R. Mackenzie.

THE first post-war dinner of the Thirty Club will be held at the Trocadero Restaurant, Shaftesbury Avenue, on Friday, May 16th, 1947, at 7 p.m. for 7.30 p.m.

Will any members who have not yet notified the Honorary Secretaries of their intention to be present, please communicate with Sir John Conybeare, Guy's Hospital, as early as possible.

Goitre

A Lecture delivered at Guy's Hospital Medical School on July 2nd, 1946,

by MAURICE CAMPBELL, O.B.E., M.D., F.R.C.P.

CASES of goitre may be sporadic or endemic; they may be associated with hypothyroidism, with a normal degree of thyroid activity, or with hyperthyroidism; they may show smooth enlargement of the thyroid as a whole or they may be adenomatous. That gives a great many possible combinations which we can divide into smaller groups. There are three main subjects I want to talk about: (1) simple goitre, (2) exophthalmic goitre or Graves's disease, sometimes called primary hyperthyroidism, and (3) toxic adenoma or secondary hyperthyroidism. There is a certain relationship between them so that they run into each other, but there are certain very important distinctions.

There is no real difference between sporadic and endemic goitre. There are all degrees of liability to goitre in different areas. If an endemic area be taken it will be found that a certain proportion of people have had it in early childhood, and the number increases up to puberty, at which time or in the few years after the maximum incidence of goitre is shown, and after this there is a diminishing number. The sporadic cases are relatively few, but there is no real distinction between the two causes. This map illustrates the incidence of goitre among school children in England twenty years ago. From a county map goitre is seen to have its heaviest incidence in the south-west, the midlands and central Wales, and its lowest in east Anglia.

To take first the simple cases: these are all smooth general enlargements to start with, and tend to increase in size up to about puberty or the age of 17, and then tend in most cases to become rather smaller or to disappear, though in a proportion they persist; and among these, as the years go on, the condition will be found to be less regular and adenomatous formation more obvious. Very few people with a goitre keep it up to 40 without it becoming irregular and nodular owing to adenomatous development.

That gives the connection between simple goitres and secondary hyperthyroidism, because, when the goitre has once become nodular, active hyperthyroidism is increasingly likely to be associated with it.

Most of the cases in children require little in the way of treatment. The precise causes of endemic goitre are still uncertain, but it is related to the deficiency of iodine, and where this does not seem to be in evidence and other

causes must be responsible, it looks as if something was preventing the proper utilization of iodine. There have been several experiments in endemic areas whereby, on adding the appropriate amount of iodine, the number of people having goitre is reduced, as well as the size of the goitre in those who still have it. The amounts of iodine required are extremely small; 1·5 grains of potassium iodide daily for ten days added once a year in endemic areas is enough to bring about a substantial reduction in the incidence. Another method is to add minute amounts of potassium iodide to ordinary cooking salt—about half a gram in each kilogram of salt, so that everybody gets a small extra supply of iodine. One is dealing with a very minute deficiency and not very much is needed.

When we come to the treatment of individual cases, I should like to stress that the borderline between the natural activity of the thyroid and over-activity is much more variable in early than in later life, and therefore we must be slow in deciding that the patient would be better with half the thyroid removed. We may see the patient in a period of over-activity and it may be that that is a temporary condition which will soon settle down. In the younger patients one may often observe a physiological hypertrophy—the production of extra thyroid substance that is wanted—and sometimes that over-shoots the mark temporarily and produces a little hyperthyroidism, but often settles down spontaneously. The main treatment in these cases is to try to provide the missing iodine. Small doses of 5 minims of tincture of iodine daily—possibly for quicker results 5 minims three times a day—will generally result in some reduction, but often the treatment will have to be repeated from time to time and the patient kept under observation. By these means one generally finds the goitre settling down satisfactorily.

There is only one condition, I think, in which these young patients need surgical treatment, and that is when there is dyspnœa from obstruction by the large thyroid pressing on the trachea. Much larger thyroids will be seen in old patients than in these young persons of 14 to 17, but obstruction of the trachea will not be found nearly as often, and the reason is that it is not so much the size as the speed of the growth, particularly if there is retrosternal goitre so that it cannot expand anteriorly and therefore presses backwards on the trachea. Sometimes the degree of dyspnœa can become severe and be associated with stridor, making an operation urgent. In those cases it is no good dividing the isthmus, and a considerable portion of the thyroid must be removed; otherwise the pressure continues and relief is not really obtained. A simple test will enable one to decide whether it is an urgent matter in any case or whether one can try to reduce the size of the thyroid by medical treatment, namely, whether the patient can lie flat, without a pillow, and have no real discomfort from dyspnœa. If he cannot do that I think the thyroid must be removed, because the risk of really severe dyspnœa and even suffocation is too great for delay.

In these simple cases I have not yet discussed the stage at which it may be decided that the condition is not going to settle down spontaneously and that the patient is going to be left with a permanent goitre. Because of the risk of adenomatous development with secondary hyperthyroidism later, one must decide as to the advisability of surgical treatment. If it is a simple goitre with little adenomatous formation it is probably better left, even at that age, for another five or ten years to see whether it settles, but if at that time it is large and already becoming adenomatous, then surgical removal may be the best

treatment as a preventive measure against trouble in the future. If one side seems larger and adenomatous there is a chance of hemithyroidectomy, leaving a certain amount of substance, but such patients may need thyroid treatment for a time.

The second main group of cases are those of exophthalmic goitre or Graves's disease. I think there is no direct connection between these and the primary simple goitre and the secondary thyrotoxicosis. The disease generally starts quite quickly, and within a very short time—sometimes days, sometimes weeks—the patient will have developed most of the signs. You know the signs, and I need not go into them in detail, though there are a few points to be mentioned in some of them. Two of the signs are given in the name—the exophthalmos and the goitre itself. In the past a good deal of stress was laid on a number of different eye signs, and a good many people's names have been attached to them. I do not think it is worth remembering a great deal about this, because the fundamental thing is just the appearance of the eye. In the slighter cases it is very rarely brought out by any of the special tests so much as by a sudden look of the patient when anxious or surprised. Quite often in the slighter cases, unless the diagnosis be made at sight when the patient first comes in and is most anxious, it will not readily be made. Therefore, particularly in some of the older cases (a difference I shall be stressing later), one must keep very much alert for the possibility that the eyes are prominent. The best signs are the lagging of the lid on looking downwards and failure of convergence on looking at something close. I think that lagging of the lids as the patient looks down does sometimes reveal a doubtful case and help in differentiation.

The second point is the enlarged thyroid. In Graves's disease this is a smooth enlargement. It does not develop on an old goitre, as the increased size has come at the time of the disease, and it does not go on to the most extreme forms of enlargement. A slight or moderate increase of size is the common form rather than the great enlargement sometimes seen in long-standing adenomatous goitre. The nervous symptoms are extremely striking; tremor is the classical one among these—a fine tremor when the patient holds out his hands. It does not interfere with voluntary movements, though sometimes it may become more generalized, and the patient may feel himself very unsteady in holding a cup and liable to spill or even to drop things. But generally the tremor is only a sign of over-activity of the nervous system rather than troublesome in itself, except in matters like keeping a cup steady, where slight movements are important.

The more we know about the individual patient with Graves's disease the more we shall be struck by the mental changes that are nearly always associated with hyperthryoidism. There may be considerable changes in the temperament of the patient who may become very much more erratic and difficult to live with. A husband or wife generally knows most about that, and often has a good deal to say about the changes that hyperthyroidism produces. It is, of course, complicated because very often the situation is a psychological one. There may be psychological difficulties to begin with which are intensified by the secondary change of temperament and make the settlement of difficulties still greater. This is a good point to stress the psychological side because quite certainly a very large number of these cases are caused by shocks and worries and develop very quickly after that, and yet the disease has become a purely physical one. Although it is always an

advantage to have the patient's confidence and to get any difficulties settled that can be settled, and to have him as little worried as possible, the disease will not be cured by psychological treatment. Whilst I am certain that the trigger is fired by mental worries and anxieties in many cases, once that has happened it seems to be an irreversible process and becomes a bodily change which can only be treated and cured by physical rather than psychological methods. In that sense it is a good instance of the inter-action of those two sides.

Sometimes the mental changes go on a good deal further than that. Acute delirious changes and even acute mania may be found in a small proportion of the patients, needing treatment in a mental hospital. I am inclined to think that is less common than it used to be, probably because we have learned more about the satisfactory treatment of cases of exophthalmic goitre than in the past.

Then we come to two most important signs—tachycardia and loss of weight. If we have a patient in whom we suspect hyperthyroidism from other signs and the heart rate is normal it is extremely unlikely that our suspicions are justified. There are very few cases in which tachycardia does not give the best single measure of what the severity is. This chart shows the relationship between the percentage increase in the basal metabolism and the pulse rate, and very roughly it can be said that an increase of 20 a minute in the pulse rate means an increase of 20 per cent. in the basal metabolism. At the higher levels the pulse rate increases more rapidly than that, but in the earlier stages it gives a rough guide.

I might take this opportunity to mention Read's formula, which is not sufficiently well-known, although it was described a long time ago. It is the only way of calculating the basal metabolism without any apparatus at all. The formula is that the B.M.R. is seven-tenths of the pulse rate plus nine-tenths of the pulse pressure, minus 75, *i.e.*—

$$7/10\ (\text{P.R.}—9/10\ \text{P.P.})—75$$

You will see at once that if you take a normal pulse rate of about 74, and a normal pressure of 120–80, which gives a pulse pressure of 40, nine-tenths of which is 36, and the two are added together, making 110, the result comes to 77–75, which is nearly normal. The relationship I give you between the pulse rate and the increase of metabolism does not, of course, allow for pulse pressure. The reason why that formula has not become of greater significance is that it is of no use without taking other things into account. If a patient has aortic incompetence he has a large pulse pressure, and that would make him appear to have a high basal metabolic rate, but that is not so. Read's formula is only true if the increase in pulse rate and the increase in pulse pressure are due to hyperthyroidism, and in a doubtful case coming for diagnosis that is just what we want to find out, so that the formula is of no help; but where it is of help is in a case in which, supposing one has got one determination of the basal metabolism, and calculates what it ought to be on Read's formula, one wants to see how the basal metabolism is behaving in the future without any further laboratory help: it is almost certain then that changes in the pulse rate and pulse pressure do depend on the degree of the activity of the thyroid.

The second symptom, the most cardinal of all after the tachycardia, is loss of weight, and on those two together you will be able to form your best

clinical judgment as to what the B.M.R. is. I am emphasising this side because the B.M.R. is a fairly difficult determination and errors can arise both in the machine and in the calculations. Therefore, if a result seems strikingly at variance with the patient's pulse rate and loss of weight it should be repeated and checked to be sure it is genuine. Otherwise one may sometimes be led very much astray.

That gives five symptoms as really important, namely, eye changes, goitre, tremor, tachycardia, and loss of weight. Other symptoms are much more erratic, but we do get some patients with attacks of diarrhœa are a very persistent and troublesome symptom ; we get sweating in most cases, very troublesome again, and we may get skin changes, sometimes with rather striking leucodermic patches.

One point of differential diagnosis that needs a great deal of emphasis is that the ordinary patient with an anxiety state often has some tachycardia, often some tremor, and may have a little fulness of the thyroid, so that one may wonder whether his is an incipient or slight case of exophthalmic goitre. It is a most important differential diagnosis because experience shows that such cases, even though they sometimes have genuinely a little over-activity of the thyroid secondary to their anxiety state, are helped hardly at all, or may be made worse from the point of view of ultimate treatment, if too much attention is concentrated on their thyroid and particularly if they are subjected to operation. It is necessary to make a very real distinction between a patient who has hyperthyroidism and whose mental symptoms depend on that, and a patient with a primary anxiety state coupled with a little over-activity of the thyroid, and although both sides are affected in both cases, it is only treatment of the fundamental primary condition that really helps. I think the pulse rate affords the greatest help in such cases, because, although one may get some quickening in the anxiety state, it will generally settle down fairly well at rest.

The differentiation of secondary hyperthyroidism from exophthalmic goitre or Graves's disease is not universally accepted. But it is an extremely valuable distinction because the course of the two diseases is so different. The secondary cases do not have any sudden nervous onset ; the development is a gradual one occurring in a patient who has had goitre for years, for so many years, indeed, that he will rarely draw one's attention to the fact, and has often become extremely good at wearing clothes of a particular style which hide it as much as possible.

Therefore we need to remember these cases. I stress this because the eye changes are much less in secondary hyperthyroidism than in primary Graves's disease, and the acute nervous side is also less marked. These differences might make one think it to be a less serious condition, but the cardiovascular side is much more serious in the secondary cases and the disease is much more progressive. Primary hyperthyroidism tends to run a natural course of its own towards cure even without treatment. If a patient could rest for two or three years and lead an easy life during that time under general medical supervision, he would probably in most cases recover—perhaps one patient in ten would go on to complete recovery, but good recovery would be reached in one half, leaving some slight signs, but enabling the patient to lead a reasonably normal life and earn his living. But in the secondary cases the tendency would almost certainly be steadily to get worse, so that it is no good thinking that any less active treatment will be called for if the patient be given a preliminary period of rest. The fact that the cardiovascular side

is so much more serious in that condition, too, makes these cases particularly suitable for surgery and really makes it the treatment of choice.

Coming to treatment, the first question is the effects of rest. I have said that if these primary cases are rested a considerable degree of improvement will be obtained, and the B.M.R. will fall some way in the course of three or four months' rest. But that is, after all, a slow business, and many people would rather have an operation than three or four months' rest, particularly as they would have got much further towards a complete cure after an operation than after rest.

Treatment with iodine has had a curious history. It was used about 120 years ago in the treatment of goitre. Over twenty years ago there was a discussion on the subject at the Royal Society of Medicine which evoked sufficient interest to be carried on for three successive meetings, and iodine was never mentioned in that discussion, showing how completely that treatment had disappeared, partly because it is not a very effective long term treatment, and partly because people had got a little frightened about the possibility of producing hyperthyroidism by too much iodine treatment in some other cases of goitre. It was really reintroduced by Plummer shortly afterwards. Lugol's solution is nearly as old as the original discovery, but the actual solutions he used were much weaker than what goes by his name now. The essence of his preparation is keeping the iodine in solution more readily with potassium iodide. The ordinary solution is 5 per cent. iodine in 10 per cent. potassium iodide. This has been an enormous asset to treatment, and the chart shows how much more quickly the basal metabolism comes down with iodine treatment than with rest. There are different views as to how this solution ought to be used, but there is not much evidence that one way is better than another, whether one works it up gradually or goes fairly quickly with a dose like 10 minims t.d.s., or even 15 minims t.d.s.; with these great improvement in the general condition and in the B.M.R. is obtained within about 10 days. The disappointing thing about this treatment is that supposing the iodine is continued in the same or rather smaller doses the patient relapses, not, as a rule, back to the original point, but some way back. If it is given a second time it is probably not as effective as the first time, and the same applies to further periods of treatment. Although it is possible to get some further improvement with it, its main possibilities are lost, and therefore if surgery is going to be considered in a particular case, prolonged iodine treatment is a bad preparation. The permanent cure of the patient with iodine is unlikely, but occasionally, though not frequently, steady improvement may be seen.

Until the introduction of thiouracil during the war, this was the only drug that was effective, apart from bromides and sedatives. Quinine hydrobromide had a special reputation as one of the best sedatives in these cases. But on the whole there has been a considerable swing in my medical lifetime towards surgical treatment, mainly because the improvement in surgical technique has made it so much less dangerous an operation than before. The risks were so great in the early stages that the slow and imperfect result with medical treatment was regarded as the best line to follow.

A third line of treatment is X-Ray treatment. Deep X-Ray treatment has had a lot of very enthusiastic devotees, and there is no question that the activity of the thyroid can be reduced by that means. One specimen shown in the museum was reduced sufficiently to get well marked myxœdema. Yet I do not think that X-Rays really have any great place. My own feeling is that

a choice should be made between the rather prolonged rest with medical treatment and surgical treatment, and that deep X-Ray therapy is a rather poor substitute in the patients who refuse operation. I was never impressed by it because I have never seen a case where the more serious heart changes, such as auricular fibrillation and congestive failure, have been abolished by deep X-Ray therapy, while it is common for these to be abolished by surgical treatment. In fact we have the rather anomalous position in cases of secondary hyperthyroidism that the worse the patient's heart the more certain it is that the right treatment is operation, because it is the only hope in those cases of getting a satisfactory result.

How far has thiouracil modified those views? There is no question that it is extremely effective, more effective than deep X-Ray therapy ever was, in the sense that it stops auricular fibrillation and helps to cure congestive heart failure. That is to give it a high testimonial and to put it up at once as a serious rival to surgical treatment. It works in nearly every case. Perhaps it leaves the thyroid enlarged, and has less tendency to cure the exophthalmos, but surgery sometimes leaves a fair or moderate degree of exophthalmos after the other things are cured. The main risk is agranulocytosis, but that risk is present throughout the treatment, and the real drawback is that one has got to go on more or less indefinitely with a treatment that needs a certain amount of supervision. Until something rather better than thiouracil is discovered, which the patient can take with less supervision, one is not going to be happy about a treatment that needs such continuous after-care.

In a sense neither thiouracil nor surgical treatment deals with the primary cause, which is almost certainly pituitary over-activity, stimulating the thyroid, and although we have learned much of the pituitary theoretically, we have learned painfully little about the treatment of pituitary disorders. It may be that the final treatment of both these varieties of hyperthyroidism will be some way of influencing the pituitary rather than of influencing the effects. I am more doubtful in the case of secondary hyperthyroidism. It seems to me one is getting there nearer to the real source of the trouble with surgical treatment. Although impressed with the effectiveness of thiouracil treatment I am surprised to find when a patient actually comes before me for a decision that I still lean to surgery in most cases.

The next few years should settle the position of thiouracil, and it may be that some improvement in this respect will diminish the risks, and one may find that a larger proportion of patients do not need to continue the treatment indefinitely, because there have been reports of isolated cases where the improvement produced by thiouracil is maintained without continued treatment.

A Case of Acute Myeloblastic Leukæmia

By a Village Doctor.

THIS case well illustrates the dramatic suddenness of onset and the almost explosive course and termination which may distinguish this disease in the young. It also emphasises a point that is sometimes overlooked, *i.e.*, that any given disease does not necessarily exhibit *all* the signs and symptoms which must perforce be categorised in its text-book description. In a very large number of cases, however, it will usually provide sufficient data on which to base a diagnosis.

A call was received about 10 a.m. to see a school-girl, aged 12. The history as given by the mother was that she had been perfectly well and at school on the previous day, but on waking in the morning complained of a sore throat, swollen glands in the neck, a headache and feverishness.

On entering the bedroom I saw her sitting up in bed, her face rather flushed, smiling and cheerful and amusing herself with her paintbox.

Her temperature was 103°, her tonsils were enlarged and looking a very bright red, as were the posterior wall of the pharynx, the soft palate and uvula, and her tongue which had the strawberry-like appearance which suggests scarlet fever. Her teeth were clean and the gums and buccal mucous membrane had the same bright red appearance, but looked quite healthy. Except for the enlarged tonsils and the hyperæmic appearance of the mouth and throat there was no apparent cause in that area for the enlargement of submaxillary and cervical glands. This enlargement was only moderate, but they were all very tender on palpation. She had no joint pains nor pains in the back and limbs. Chest and heart were normal. There was no rash and no circum-oral pallor.

Having a long visiting list and being perhaps over-anxious to get on with it, I thought there was quite enough in her throat to account for her condition and that there was no need to do a fuller examination. Circumstances were to prove how wrong I was. It is worth noting here and now that with practice, a comprehensive physical examination can be run through in a very short time *and it should never be omitted, especially when seeing a new illness in a patient whom you may have seen many times before for other conditions.* Never allow expediency to tempt you from the straight and narrow path or you will regret it sooner or later.

I told the mother that the child's tonsils were swollen and that her tongue suggested the possibility of scarlet fever; that if it were going to be scarlet fever a rash would appear on the following day. I said that the sore throat and the enlarged glands were all part of the same picture and that time would show whether it was the whole story or whether it might be part of something which might develop later. Looking back, this was a very fair and reasonable statement.

A mixture of salicylate of soda and acetate of ammonia was prescribed, with a thymol and glycerine gargle.

About 12.30 the same day, I was intercepted at the house of another patient by a telephone message, saying that the girl's nose was bleeding profusely and her headache was much more severe. I returned to the house and found that the nose was still bleeding, so I plugged it tightly with half-inch ribbon gauze. The mother was told that the nose-bleeding would probably relieve the headache. This was really a very silly thing to say. She had obviously lost quite a lot of blood and the headache was not better but worse. It was one of those stupid attempts at rationalisation with which every doctor at some time or other has fobbed off the questions of relatives and it is apt to become a habit, so don't do it. One day it will make you look a fool. It certainly made me feel one later in the day.

If I hadn't been so anxious to get through a long visiting list, this nose-bleeding should have made me think. I should have made a fuller examination, including the liver and spleen, both of which I found to be enlarged when I did so later. Not that it would have saved the patient's life. But

the fact remains that I overlooked it. Having reassured the mother, I resumed my visits.

Just after three o'clock in the afternoon I was again intercepted by phone this time to say that the patient was screaming, delirious and violent and had to be held down in the bed. She was said to keep hitting her head with her fists, and the nose was bleeding through the plugs. Would I please go at once. I hurried through with the patient I was seeing, thinking much less about him, I am afraid, than about the delirious girl.

On my way to the house I had made a tentative diagnosis. The screaming, delirium and violence suggested meningitis. The sudden onset, with sore throat, enlarged glands followed by profuse nose-bleeding . . . what about an acute leukæmia? Was not the whole sequence of events too rapid? No, I didn't think it was. I must get some blood films and have a look at her liver and spleen. I'd better give her something to keep her quiet, if only for the sake of the relatives.

A village doctor learns by experience to carry a small but very comprehensive kit in his car, suitable for most emergencies of treatment and diagnosis. I may send the *Gazette* a note on this some time later.

We may skip a description of the state of the bedroom on my arrival. Not only the bedclothes, but a neighbour and an aunt who had been holding the patient down were well plastered with blood. I gave her gr. 1/150 of hyoscine and gr. $\frac{1}{10}$ of morphia which soon quietened her, except for an occasional scream. Her pupils were widely dilated and a quick look at her fundus showed extensive hæmorrhages on both sides so that she must have been quite blind. Both liver and spleen were easily palpable. I then took three blood slides and explained that I would return immediately I had examined them.

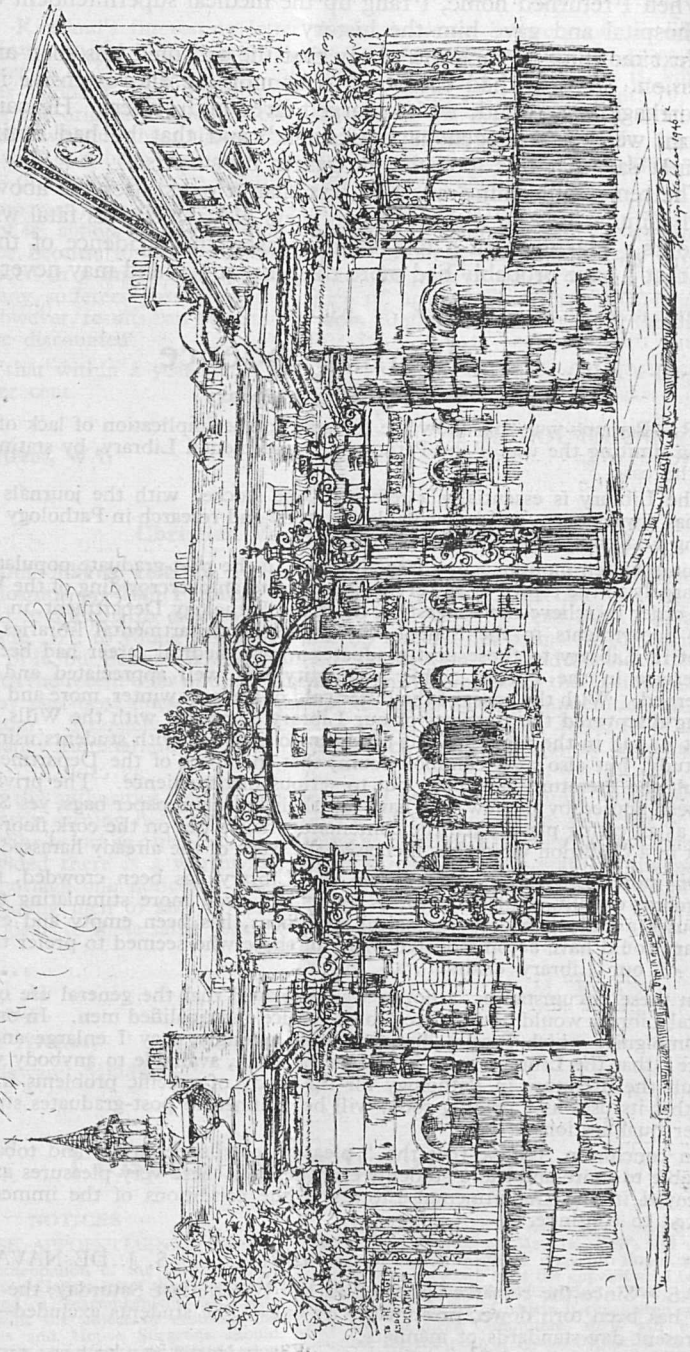
At home it took a matter of a quarter of an hour to stain with Leishman. When examined under the microscope every field was crowded with myeloblasts.

I returned to the house and told the parents that she was suffering from a very acute and fatal form of blood disease and that the end could not be far off. They asked whether they could have a second opinion and I said I was willing to meet anybody they liked to suggest. I now think this was a mistake, and that I should have named the consultant. They wanted to call in a Dr. X who had a considerable local reputation in confinements, so I rang him up and he said he would come at once. It was immaterial whom she saw.

When he came, I outlined the history and told him what I had found in the films. Then he examined her and we retired to discuss the case. Apparently he ignored my finding in the blood film and agreed that there were signs of meningitis, which I ascribed to probable intracranial hæmorrhage, but he thought might just as well be due to cerebro-spinal meningitis. He thought she should go to hospital to have the chance of sulphonamides or penicillin. I thought she should not be moved, as I felt the end was not far off.

We explained to the parents our difference of opinion and they, feeling that I was a mere new-comer to the district, quite understandably decided to do what Dr. X. recommended.

I asked if he would arrange removal to hospital, which he consented to do, " to give her a chance," and the local isolation hospital agreed to take her.



When I returned home, I rang up the medical superintendent of the isolation hospital and gave him the history.

Next morning he rang me to say that the girl died less than an hour after admission. A P.M. had been done that morning and extensive intracerebral hæmorrhage was found, with enlarged liver and spleen. He said the P.M. findings were " Myelogenous Leukæmia," and that he had notified Dr. X. I cannot say that this took me altogether by surprise.

The remarkable thing was that less than a week after the above, I had an exactly similar case in a child of two years old, which was fatal within thirty-six hours. Having seen a total of five cases, the incidence of the disease is such that I have probably had more than my quota, and may never see another case.

Correspondence

Pathology Library

SIR,—Perhaps you will allow me to reply to the implication of lack of public spirit in limiting the use of the Pathology Departmental Library, by stating the facts of the case.

The Library is essentially a reference one stocked with the journals of Pathology and has always been, and is, available for study and research in Pathology to any person willing and competent to do so.

Some fifteen months ago, a large increase in the post-graduate population of Guy's, due largely to the return of ex-service men, led to an overcrowding of the Wills Library, so in order to relieve the congestion there the Pathology Department, in common with other departments in the School who possessed departmental libraries, allowed the use of its Library to those post-graduates whose medical career had been interrupted by service in the Forces. This hospitality was well appreciated and benefited all concerned. With the onset of the bitter cold of the past winter, more and more students having discovered the comforts of our Library compared with the Wills, began to frequent it, and in the recent past it has been so crowded with students using it, not only for study, but also as a common room, that members of the Department wishing to consult the literature have been put to serious inconvenience. The privilege accorded has been abused by the few who have left their luncheon paper bags, yes Sir, it has been used as an eating place, shed the contents of their pipes on the cork floor and generally eft it in a condition which has increased the work of the already harassed cleaners.

On more than one occasion when the Library has been crowded, the Pathology classroom, equally available, just as quiet and even more stimulating to study since it houses a collection of pathological specimens, has been empty and even the Wills Library could have accommodated many of those who seemed to prefer the red leather seats of our Library chairs.

In these circumstances, a notice was displayed that the general use of the Departmental Library would be restricted to ex-service and qualified men. In order to remove the ambiguity which Passim disapproves so strongly, may I enlarge and qualify this notice : that the Library is, as it always has been, available to anybody who wishes to consult the literature in Pathology for the study of specific problems in that science, and that its uses as a reading room will be confined to post-graduates studying for the higher qualifications.

In conclusion, I hope that the " pleasure of silence, study and tobacco " will be available to more and more students elsewhere, as these very pleasures are likely to be destroyed in the Departmental Library if the conditions of the immediate past are allowed to continue.

I am, etc.,

S. J. DE NAVASQUEZ.

P.S.—Since the remarks appeared in the *Gazette* last Saturday, the notice on the door has been torn down, presumably by one of the students excluded—a fair sample of present day standards of manners.

Pathology Department,
Guy's Hospital.

Treatment of Migraine with Urea

SIR,—Dr. Kirkland's interesting letter discloses his re-discovery of the apparent value of urea to the migrainous. It was first described about eight years ago in the *Lancet* or *B.M.J.* (I cannot unfortunately trace the article). It is, however, referred to as standard empirical practice by S. Nevin, *Med. Press*, Sept. 19, 1945. Since reading the original elusive article I have used the drug frequently in doses of 10–20 gr. daily without the uniformity of success which has cheered Dr. Kirkland. Not more than 1 in 4 have improved. In these cases the result has been remarkable, the frequency of attacks has been greatly reduced or even abolished.

Urea compares favourably with phenobarbitone as a preventive. No rational explanation of its action has been vouchsafed. If I remember rightly, it was used in the first place because it was a diuretic. The reasoning was that urinary excretion is often reduced in a migrainous attack and for an hour or so before it. Following an attack many sufferers pass large quantities of urine. Therefore, urea might do good! If, however, results can be obtained from 20 grains t.i.d., obviously the diuretic action can be discounted.

I believe that within a year Dr. Kirkland's successes will have fallen a long way below 100 per cent.

I am, etc.,

A. H. DOUTHWAITE.

44, Harley Street, W.1.

Christian Vocation in Nursing

SIR,—I would like to refer to a resolution passed by an Evening Conference at Guy's Hospital on 27th February and reported in your *Gazette*.

I find it difficult to express the disgust with which I read that "an appeal should be made . . . to young women to take up nursing not primarily for what they could get out of it, but because it was a Christian obligation 'to tend the sick.'" This is on a par with the recent offer of the Medical Officers of Health for the London County Council to pay part-time nurses and midwives the magnificent remuneration of 2*s.* to 2*s.* 3*d.* per hour. Strangely enough they also found it necessary to add—of course it isn't the money but the nobility of the work which really matters—or words to that effect!

When will the authorities stop this humbug and realise that a nurse—like everyone else—is primarily earning her living and wants a salary comparable with that of other professions. She is just as capable of undergoing as rigorous a training as, say, a medical student—provided there is a worthwhile object at the end. In spite of the present man-power shortage one notices it has not been necessary to make these "Christian appeals" to young men to take up medicine! Personally, I suggest the responsible person also appeals to these same young women to take a vow of poverty.

Yours, etc.,

M. RYAN.

16, Albany Court,
Montrose Avenue,
Edgware, Middx.

Hospital Information, etc.

NOTICES

HOUSE APPOINTMENTS.

On the recommendation of the Medical Committee, the Court of Governors of the Hospital has recently approved a rearrangement of House Appointments, with the object of ensuring that House Physicians and House Surgeons should, in future, have the opportunity of gaining more experience before taking up these responsible appointments.

The appointment of Assistant House Surgeon will be reinstituted on May 1st, 1947, and will be held by newly qualified men for three months. Thereafter they will hold the appointment of Out-Patient Officer for a further period of three months, on the termination of which, if considered suitable by the Medical Committee, they will become eligible for the post of House Physician or House Surgeon (B.2 appointments) for a period of six months, not more than two candidates, as a general

rule, being appointed House Surgeon or House Physician in any three months.

So long as Ex-Service men are available, the following appointments will be open to them :—

House Physicians (6).
House Surgeons (2).
Children's House Physicians (2)—(1 non-resident)
Neurological House Physician (1).
Resident Obstetricians (3).
Fracture House Surgeon (1)—(non-resident).
Back Surgery House Surgeon (1)—(non-resident).
Dermatological House Physician (1)—(non-resident).
Ophthalmic House Surgeon (1)—(non-resident).
Ear, Nose and Throat House Surgeon (1)—(non-resident at Guy's).*
Resident Clinical Pathologist (1).

* The Ear, Nose and Throat House Surgeon will be appointed for six months, with three months tenure of office at Guy's, followed by three months at Orpington.

STUDENT HEALTH SERVICE.

Owing to the fuel shortage and the consequent scarcity of X-ray film, it has been impossible to do any routine radiological examinations for the Student Health Service recently.

These radiological examinations will start again on April 14th, 1947. Students will be notified of their appointments both by a general notice appearing in the College and on the Health Service notice board in the entrance to the Medical School and also individually by letters placed in the rack in the Colonnade. Owing to the recent difficulties, there are considerable arrears of work in connection with these examinations, and students are particularly asked to keep their appointments whenever possible. The Secretary to the Service will be pleased to make an alternative appointment where necessary if adequate notice be given.

W. N. MANN,
Director.

DEPARTMENT OF SURGERY.

On Tuesday, April 15th at 12 noon, there will be a further demonstration in the series " Operative Procedures " in Theatre No. 2.

At 10.30 a.m. on Saturday, April 26th, there will be a Clinico-Pathological Demonstration in the Anatomy Lecture Theatre.

During the second half of April there will be an exhibition in the Gordon Museum, illustrating Surgery of the Thyroid Gland.

PASS LIST

CONJOINT BOARD.

FIRST EXAMINATION.
March, 1947.

Anatomy.

D. Barker — J. F. Le Clus

Physiology.

D. Barker — J. F. Le Clus

Pharmacology.

D. A. Ager — K. M. S. Hume
L. C. Bellsham-Revell — Q. F. Neettiling
D. G. Chalmers — J. T. Owen
A. W. Cook — K. I. Porges
A. K. Doust — N. A. Power
E. W. Graham — W. J. S. G. Rhys
J. R. Greaves — P. Sattin
M. W. J. Grummitt — B. J. Silkoff
F. A. De Hamel — R. G. M. Stobie
M. Hatton — J. D. Williams
G. E. Haward

UNIVERSITY OF OXFORD.

B.M., B.Ch.
Hilary Term, 1947.

Forensic Medicine and Public Health.

D. P. Winstanley.

Social and Clinical Pathology.

R. A. Bruce — I. Kelsey Fry
R. E. A. Hansen — A. G. Parks
R. Haward-Davis — D. P. Winstanley

SOCIETY OF APOTHECARIES OF LONDON.

FINAL EXAMINATION.
March, 1947.

Pathology, Bacteriology and Forensic Medicine.

D. M. H. Bickmore.

Medicine.

R. D. C. Hart.

PAPERS BY GUY'S MEN

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CHANGES OF ADDRESS

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APPOINTMENTS

Brigadier Grant Massie, C.B.E., is included in the list of honorary consultants to the India and Burma offices in recognition of services as consultant to G.H.Q. India.

D. A. Davies, M.D., M.R.C.O.G., has been appointed Obstetrics and Gynæcological Surgeon, West Middlesex County Hospital, Isleworth.

Felix N. Corfe, M.R.C.S., L.R.C.P., L.D.S., R.C.S.Eng., has been appointed Assistant Dental Surgeon, Royal Northern Hospital, London, N.7.

BIRTHS

HOLLAND.—On March 3rd, 1947, at Nuffield House, to Betty (née Lambert), wife of Roger Holland—a daughter.

THORNE.—On January 18th, 1947, at Guy's Hospital, to Dorothy Thorne (née Poole), wife of M. G. Thorne—a daughter (Catherine).

VULLIAMY.—On March 18th, 1947, at Guy's Hospital, to Daphne, wife of David G. Vulliamy—a son.

WALTHER.—On March 26th, 1947, at The Granary, Bramley, to Bobbie (née Brook), wife of D. P. Walther, M.R.C.S., L.D.S.—a daughter (Philippa Jane).

WATERS.—On March 5th, 1947, at Ismailia, M.E., to Bep (née Morris), wife of Dr. I. R. Waters—a brother for David (Christopher).

DEATHS

TAYLOR.—On April 2nd, 1947, in Guy's Hospital, Elizabeth, the baby daughter of Audrey (née Wright, S.R.N.) and Johnson W. Taylor, aged 10½ months.

EDS. { D.H.F. / H.A.R.

GUY'S HOSPITAL GAZETTE

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PASSIM

THIS Hospital, with its great surgical tradition, must, if it wishes to retain its pre-eminent position, see to it that it provides two things: an impeccable and progressive surgical service for its patients, and a first-class surgical education. The perfection of the surgical service will depend partly on its organisation, accommodation and equipment, partly on the skill of the surgeons in that service. The standard of surgical education will depend in part on the ability of the officers of the Hospital to teach, and in part on a wise and imaginative correlation of those talents.

The Surgical Department was established as a result of the Goodenough Report, with money made available by London University, little over six months ago. Six months is a very short time in this slow moving post-war world of ours—so short a time in fact that one might well have expected that by now nothing more than a little planning would have been done, planning to fulfil the requirements mentioned already.

The development of an organisation, with accommodation and equipment that will suffice, is inextricably bound to the cogs of the national machine, and the tempo of progress must inevitably be governed by the limitations on commodities and manpower, the dictates of shortages and priorities. At the moment the wheels turn slowly and we can only say that when the plans of the New Hospital are being made, the director of the department will be found on the Post-War Planning Committee. In this present reparative stage of mend and make-do he advises on the modifications and equipment of theatres, wards and out-patients, and even that one-time limbo of chronicity, back-surgery, comes under his ægis.

It is in the training of surgeons and the teaching of general surgery that, so far, the real progress has been made. Much more than a little planning has been done in the past half-year, and whereas the constantly recurring notices in each issue of the *Gazette* bear testimony to the activities of this department, those activities have to be attended to be fully appreciated.

At 10.30 a.m. on the fourth Saturday of each month, a Clinico-Pathological meeting is held. This has been described (not only by people from this Hospital, but also by post-graduates from outside) as the best demonstration they have known of how surgery should be taught. Cases having been presented, surgeons, physicians and pathologists expound their views, with the lantern, blackboard and tissue specimens for illustration. At present the theatre is incompletely filled, although one cannot but marvel at how well filled it is for a Saturday morning. We believe, however, that when it has become more universally known how unspeakably stimulating these meetings are, there will be few seats left vacant.

At ten o'clock on the second Saturday of each month a departmental round is held in the surgical wards. Cases are collected and selected which are of particular interest. So far these rounds have been taken largely by our own gods, but Sir Stanford Cade came to conduct one a short while ago, and other distinguished surgeons from outside are coming at future dates. The teaching is essentially post-graduate, and old Guy's-men are cordially invited. Can one say more than that to hear these Olympians discussing their Olympian topics reminds one of the great combined rounds in the days of Sir Arthur Hurst?

In the Gordon Museum there is now always to be found a demonstration of some section of surgery, embracing pathology, symptomatology, complications and treatment, with excellent typed explanations, selected bottled specimens, caricatures, diagrams, X-rays and apparatus. At present changed every month it is hoped in the near future to be able to change it fortnightly.

In the Surgeons' room at the top of the surgical block a surgical library is gradually accumulating, where reference books and journals may be read before ten o'clock. A recent and most generous gift by Mr. Davies-Colley of over a hundred volumes, including a complete set of The New Sydenham Society's publications, is, we learn, shortly to be added to it.

Finally, on alternate Tuesdays at noon a demonstration of operative procedures is given by the director, in theatres, and we have had a film on varicose veins and a display of amputation stumps which are the precursors of further similar features.

The present Final Fellowship Course, besides thirteen people from the British Isles, includes twelve people from South Africa, six from Australia, two each from Canada, New Zealand and India, and one from America, China and Egypt. These people will disperse in time to the four corners of the world, and will take with them their impressions of Guy's. Their comments on the Fellowship Course and on the various other functions of the Department of Surgery have been a great source of pride to those of us who have heard them. We too, brought up in Guy's, and not only taking advantage of the new facilities, but also interested in seeing our hospital keep its nose in front of the main crowd, would like to add our tribute.

This child, bred out of a government report by a university grant, is, we repeat, *but six months old.* But nursed and nourished by the director with great tact and imagination—more than that even, with a sense of showmanship, which alone can make learning not only pleasurable but almost an adventure—it has reached astonishing maturity already. Mr. Atkins is not only to be most warmly congratulated on his achievement, but to him, and to those who at his instigation so enthusiastically lend their time and co-operation, we owe a great debt of thanks.

Notice of the death of Dr. Walter Ramsden will be found elsewhere in this issue. A most distinguished Guy's man, he was Senior Fellow of Pembroke College, Oxford, and Emeritus Professor of Biochemistry in the University of Liverpool.

A few copies of the *Gazette* have become available for nurses about to leave the Hospital who wish to become annual subscribers.

Carcinoma of the Colon

A Lecture delivered at Guy's Hospital by CHARLES P. NICHOLAS, F.R.C.S.

GENTLEMEN,—In accordance with my belief that surgical text-books are usually out of date and often singularly lacking in interest on many important subjects, I shall bring to your notice, this afternoon, certain recent facts which are now well established about Carcinoma of the Colon, before proceeding to the more commonplace aspects of the disease. There is still a dangerous tendency to look upon carcinoma of the colon as an incurable disease and upon the unfortunate patient as a candidate for the post-mortem room in the not far distant future. Nothing could be further from the truth as the figures which follow will, I hope, prove to you. Let us therefore first consider the question of prognosis as an index of the progress which surgery has made in this field in the last ten years.

In assessing prognosis, operability (which is the number of cases in which complete eradication of the growth is possible), operative mortality, and expectation of life after adequate removal of the carcinoma must receive consideration. Prior to 1939 the operability rate was on the average 50–60 per cent. To-day it is about 80 per cent. Cattell's figure for 1943 was 84 per cent., A. W. Allen's 91 per cent., and Wangensteen's as high as 93 per cent. The operative mortality has shown a simultaneous and equally striking decline from about 20 per cent. in 1939, though Ochsner and De Bakey's figure was as low as 14 per cent., to 5·1 per cent. in 1942 in 879 cases studied at the Mayo Clinic. Gordon-Taylor's figure for 138 cases operated upon up to 1942 was 5 per cent. and it is encouraging to get one over, or perhaps I should say, point one over the Americans.

The expectation of life has also greatly improved. Cattell in 1944 had 55 per cent. of five year survivals and many were still alive after 9 years. Dixon's figures for five year survivals up to the same year are even better; 72 per cent. for the right colon, 63 per cent. for the descending colon, and 44 per cent. for the sigmoid. From these figures you will see that the prospect of cure decreases from the cæcum through the more distal segments of the large bowel to the sigmoid; we are not of course considering the rectum. I advise you to take these figures down, though not necessarily to commit them to memory, for you will then have for reference a permanent record of 10 years progress in the surgical treatment of carcinoma of the colon. They will be of use to you in general practice when, before referring your patients to the surgeon, you should know what are the hazards of operation and what the prospects of cure. The patient will, on occasion, ask you what are the risks and what the chances of success. I hope that you will see fit to recommend operation and to reassure your patients of the prospects of complete and lasting cure offered by careful surgery.

Let us consider the factors responsible for this improvement in prognosis from an operative mortality of 20 per cent. in 1939, with about a 30 per cent. expectation of a five year survival, to a 5 per cent. mortality at the present day with a 55 per cent. chance of a five year survival taking all cases; or a 72 per cent. chance in the case of the cæcum and ascending colon. It is indeed heartening in these days of gloom and uncertainty with such a clouded and stormy horizon, to be able to jump into the bright realms of surgery.

The reasons for so great an advance are first, earlier diagnosis by improved radiology and routine sigmoidoscopy, about which I will tell you more later, secondly the great advances which have been made in anæsthetics enabling the surgeon to perform longer and more extensive operations and so to render possible complete extirpation of even fixed and spreading growths, perhaps invading other viscera such as the spleen in the case of the splenic flexure, or the stomach in the case of carcinoma of the transverse colon. Then there is the better understanding of the mechanism of shock and its adequate treatment by plasma, and the treatment of blood loss by safe transfusion enabling the blood volume and the oxygen carrying capacity to be maintained at normal level at all times even when considerable hæmorrhage has occurred.

There is what is known as the "chemotherapeutic umbrella," whereby Sulphasuccidine is administered pre-operatively to eliminate the *Bacillus Coli Communis*, normal inhabitants of the large bowel and harmless enough in their accustomed place, but organisms capable of creating havoc should they escape from the suture line of an anastomosis and gain access to the peritoneal cavity, where they will rapidly set up a dangerous peritonitis.

The importance of adequate vitamin C in the diet, of a normal blood protein and fluid balance as essential preoperative desiderata, and their maintenance throughout operation, the postoperative period and convalescence has only been fully appreciated in the last ten years. It is just in these very cases of carcinoma that there is malnutrition, a fact which has long been appreciated, but that the cachexia is due to anæmia, lack of essential vitamins, hypoproteinæmia, dehydration and azotemia has only been established of recent years.

The surgeon has learned not to attempt a resection or an anastomosis in the presence of obstruction, nor even in the presence of a loaded bowel, and I will dwell further upon this aspect when we come to consider treatment. The introduction of the Miller-Abbott tube has made possible deflation of the bowel preoperatively in cases attended by acute obstruction. It is said that 30 per cent. of carcinoma of the colon come to the surgeon in acute obstruction, which is probably true of the left colon but seems too high to refer to all cases. Again the Miller-Abbott tube has improved the treatment of postoperative paralytic ileus.

Lastly, the adoption of stage operations and multiple resections when the growth involves several viscera has lessened greatly the operative mortality.

Thus two of the three main causes of operative mortality, namely, peritonitis and paralytic ileus, are to-day more often prevented and, if established, more often corrected and the fatal issue averted. The third common cause of death, necrosis of the suture line due to interference with the blood supply on either side of the resection, is still a hazard but the danger is well known and is in the fore front of the operating surgeon's mind who is thus forewarned and the patient so forearmed.

Having considered these interesting and hopeful aspects of colon carcinoma surgery, let us turn to the clinical aspects.

Carcinoma of the colon occurs most commonly between the ages of 40 and 60, but cases under 30 and over 80 are known, and you should be on the look out for such cases for these are the very ones you are likely to miss. Growths of the left colon are twice as common in men as in women. In the right colon the sex incidence is reversed. The sigmoid is most commonly

affected, next the cæcum and ascending colon, transverse colon, descending colon, hepatic flexure in that order, and least commonly the splenic flexure These figures, which I advise you to study, are based on the records of 625 cases examined by Judd at the Mayo Clinic :—

Sigmoid	46·7 per cent.
Cæcum and ascending colon	25 ,,
Transverse	12 ,,
Descending	7·4 ,,
Hepatic flexure	4·6 ,,
Splenic flexure	4·0 ,,

You may well ask, " What is the reason for the distal large bowel being more often affected by carcinoma than the more proximal segments." As you see there is an increase in incidence from cæcum to sigmoid if we remember that the 25 per cent. for cæcum and ascending colon refers to a much larger length of bowel than the other figures. The theory suggested by Cuthbert E. Dukes is based on the established fact that the higher the concentration of carcinogenic substance the more often does carcinoma develop in the tissue exposed to it. The passage of fæces in the colon becomes slower and the fæces more concentrated from right to left so, if there be a carcinogenic substance in the fæces, it will be dilute in the cæcum, and many times concentrated (and the mucosa of the bowel longer exposed to it) in the distal large bowl and sigmoid.

The Symptoms of the disease are fortunately now well-known and in general are these :—A change in bowel habit. The patient whose bowels have been quite regular for years, be it a daily motion or one every two or even three days, becomes increasingly constipated and irregular in his habit, and resorts to larger doses of aperients in an attempt to recapture the even tenor of life of his bowel, but with a singular lack of success. Whether or no he be taking aperients he has attacks of diarrhœa varying in duration, quite severe at times and often lasting many days, followed by absolute constipation or the unsatisfactory passage of a small stool. He may complain that whenever he takes a meal or even a few sips of tea or water he has to rush immediately to the lavatory, sometimes only to find there is nothing but the urgent desire to defaecate, and he produces no stool. At others he passes a small constipated stool or liquid motion. This is known as the exaggerated gastro-colic reflex. These symptoms may be all of which the patient complains, but there is a variety of other symptoms and a patient may present with any one or all of those I am about to describe. A common complaint is colicky abdominal pain felt below the umbilicus or in the right or left iliac fossa, and usually accompanied by a feeling of distension and relieved by passing wind. Not that I intend to suggest that all affected so are necessarily suffering from carcinoma for such uncomfortable experiences are common to us all in the event of dietetic or other indiscretions. It is when these symptoms occur without due provocation, occur often and recur with increasing severity that they should make us suspicious.

A feeling of discomfort in the abdomen after meals, nausea and loss of appetite is another not uncommon symptom complex and is described in the books as dyspepsia or indigestion, both unfortunate terms. They are likewise unfortunate symptoms for they may put the doctor off the scent of

the colon on to the false trail of the stomach, leading to the inevitable bottle of carminative medicine. The patient may have noticed blood or mucus or both in the stools and the doctor will not make light of this complaint.

Later symptoms are loss of weight and anæmia which are grouped together under the term cachexia, or the patient may have noticed a lump in the abdomen. He may be seized by the violent colicky pain, vomiting, distension absolute constipation and the prostration of an acute obstruction, or the growth may even perforate producing another variety of acute abdomen with symptoms of peritonitis.

What are the reasons for these symptoms? The change in bowel habit, increasing constipation, feeling of fullness and wind are due to increasing obstruction to the lumen of the bowel by the extension of an encircling growth, and are termed chronic obstructive symptoms. The diarrhœa, bleeding, mucus and localised pain, such as is sometimes felt as an ache in either iliac fossæ, are due to ulceration of a fungating growth. The discomfort after meals, nausea and loss of appetite are explained as a reflex effect upon the stomach resulting from abnormal autonomic afferent impulses originating in the diseased bowel and termed in the books "reflex dyspepsia." The cause of the late symptoms are self evident. We may now consider how the symptoms differ for growths of the right as compared with the left half of the colon. For instance, carcinoma of the cæcum and ascending colon, as a rule, causes reflex dyspepsia, the ulcerative group of symptoms, and anæmia; whereas those of the sigmoid cause the obstructive group. Two factors are responsible for the differences, the character of the fæces and the type of growth. In the right colon the fæces are fluid and the growth the proliferative, fungating variety of adenocarcinoma; hence obstruction to the flow of fæces is rare, but blood, mucus and diarrhœa are common. In the left colon the fæces are solid and the growth more commonly of the annular constricting type, and so obstructive symptoms are usual and the ulcerative group less common, though both types of symptoms may alternate depending on the state of the growth. Acute obstruction is not uncommon in the left colon and is usually preceded by chronic obstructive symptoms as will be discovered if a careful history is taken. The acute obstruction is caused in one of four ways, by extension of the growth and œdema, by impaction of fæces, or less commonly by intussusception.

Having discussed at some length the common symptoms we will turn to the detailed consideration of the physical signs typical of carcinoma of the colon, dealing with the abdominal signs first as you must learn to make the diagnosis on these and not wait for constitutional effects, which in general appear late and when the patient is less likely to reap the full benefit of surgery. The local signs differ to some extent for the left and right colon as do the symptoms, though there is no sharp dividing line. When the left colon is affected there are often signs of subacute intestinal obstruction, and a distended tympanitic abdomen; the distension is said to be most marked in the flanks, though this, in my experience, is by no means always the case, and there may be visible peristalsis the waves of which if watched carefully pass proximo-distally along the colon to the site of obstruction. Visible peristalsis is best seen if the surgeon places himself so that the patient lies between him and the source of light, and he should kneel down so that his eyes are only just above the abdomen. If not present, visible peristalsis may be elicited by tapping the abdomen or giving the patient a sip of water. A wave of

peristalsis often coincides with an exacerbation of pain and the patient may become distressed and roll about the bed. Auscultation over the transverse or descending colon will reveal borborygmi of increased intensity and frequency, but they will not have the metallic explosive quality of those heard in acute obstruction of the small bowel. Unfortunately such signs are often absent as in the patient whose only symptom is a change of bowel habit, and you may draw blank even after an exhaustive examination of the abdomen, but it is in these very cases that it is the more imperative to carry out the investigations I will shortly be describing to you. In some cases there may be a firm roughly spherical tumour with irregular surface and outline palpable in the left iliac fossa or left lumbar region, which may be movable from side to side or move spontaneously if the patient is made to lie on his right side.

In the case of the right colon, subacute obstruction is seldom present and it is common to find no physical signs. Sometimes there is tenderness in the right iliac fossa and a gurgling distended cæcum will be felt, but this sign may be present wherever the growth in the colon, due to back pressure. A mass similar to that I have already described may be palpable in the right iliac fossa or right lumbar region, and it may be tender if the tumour is involving the serous coat or there is secondary infection. Sometimes the local peritonitis may be sufficient to give guarding and local rigidity, both signs of impending perforation.

Rectal examination should never be neglected, though it is unusual to be able to feel a tumour in the sigmoid unless it occurs in a loop which has fallen into the pouch of Douglas, when it will be felt as a hard mass through the anterior wall of the rectum. The rectum may be ballooned if the tumour is in the bowel just above it, but the examination must be repeated after the patient has been told to pass wind to be of any value. The finger should be inspected for blood and mucus on withdrawal and it is quite commonly present In late cases secondary deposits may be felt in the pouch of Douglas.

The constitutional signs in late cases are emaciation, anæmia (evidenced by pallor of the face, nails and conjunctivæ), loose inelastic skin of the abdomen and an enlarged firm liver. Secondary deposits may be palpable as firm umbilicated nodules on the antero-superior surface of the liver.

Early diagnosis, as I have said, is in large measure responsible for the improved results of surgery. The earlier the case is referred to the surgeon the easier will be the operation and the greater will be the chance of complete cure; or failing that, the longer will the patient be free of secondary deposits. The early diagnosis of carcinoma of the colon is best made by the constant realisation of its possibility. Any patient over 35 who complains of a change in bowel habit, attacks of colicky abdominal pain, alternating diarrhœa and constipation, or the passage of blood and mucus in the stool must be fully investigated and no stone left unturned till the cause has been found, even in the absence of abdominal physical signs.

The investigations which will confirm or make the diagnosis are, inspection of the stools and their examination for occult blood if they appear normal, sigmoidoscopy, barium enema, hæmoglobin estimation and erythrocyte count. Occasionally laparotomy is justifiable.

The important, though somewhat distasteful practice, of inspecting the stools for blood and mucus in all cases should never be neglected. Sigmoidoscopy is attended by many difficulties and the instrument requires considerable

skill to pass in some cases. Success is achieved as often in an unprepared patient who has had his bowels open the same day as in the patient who has had 3 gr. of cascara 48 hours previously, followed by an enema the following morning and a rectal wash out on the day of sigmoidoscopy. If fæces obstruct the passage of the instrument or spoil the view on one day, the examination must be repeated daily until a clear view is obtained. Difficulty is often experienced at the rectosigmoid junction due to spasm. General anæsthesia may abolish this, or it may be possible to pass the instrument onwards by change of position. In the event of difficulty all three positions should be tried, the left lateral, the genu pectoral and the lithotomy, the latter always under general anæsthesia for the indecent exposure is disagreeable, especially to women. If the instrument will not pass after trying all these expedients on two or more occasions it is presumptive evidence of an encircling growth of the bowel. The examination is, of course, incomplete unless the sigmoidoscope can be passed its full length. A carcinoma when seen early is a raised irregular dark red patch on the mucosa with a broad base and granular surface which bleeds easily when touched. Later it presents as a tumour of varying size with the same surface characters and may partially or completely encircle the bowel. The large fungating carcinomata are seldom seen in the left colon. If a suspicious area is seen, which is not sufficiently advanced to make a confident diagnosis, a biopsy specimen should be obtained by means of a special punch passed through the sigmoidoscope. So much for sigmoidoscopy. The barium enema technique requires a purgative such as 3 gr. of cascara given 48 hours before, an enema 24 hours before and rectal wash out the morning of X-ray. Two pints of barium solution are then run into the rectum through a funnel and tube with the patient lying on his left side with his knees drawn up. After half to one pint has been run in he is turned in to the prone position and the rest of the barium run in. An X-ray plate of the whole abdomen is taken immediately and a second plate after the patient has emptied his bowel. When there is an encircling growth of the sigmoid the whole of the enema cannot be accommodated and the patient experiences pain. The plates show either complete filling to the cæcum with a filling defect at the site of the growth, or filling which stops short at the carcinoma depending on how much obstruction is present. Antero-posterior and oblique views must be taken of the pelvis as a filling defect may otherwise be obscured by overlap of shadows in the tortuous sigmoid colon.

Even if these views appear normal it is unwise to say that the possibility of a carcinoma of the sigmoid is excluded. Fortunately in this section of the colon where X-ray is not completely reliable, the sigmoidoscope will always reveal a tumour if present. Conversely where the sigmoidoscope cannot reach, namely, the transverse and descending colon and cæcum, a normal barium enema is strong evidence against the eventuality of carcinoma, particularly if still normal on repeating the X-ray examination in three months. Overlap of shadows again makes exclusion of carcinoma at the splenic and hepatic flexures impossible. Perhaps this problem may one day be solved by an improved sigmoidoscope or coloscope which is flexible and can be made to turn the corners of the bowel in order that the whole length of the interior of the large bowel may be visible from sigmoid to cæcum. If no other explanation for the symptoms can be found and all investigations are negative save for finding occult blood, laparotomy is justifiable. For a positive occult blood to be significant it is of course necessary for the patient to live on a hæmoglobin free diet for 7 days with a daily evacuation of the bowel before

testing the stools. The usual three days is not long enough if some degree of obstruction is present.

The pathology and spread of carcinoma of the colon no doubt has been dealt with in your pathology lectures, and although a complete understanding of this aspect is essential to the surgeon before operation, I shall not have time to go into these pathological considerations this afternoon. Likewise I have time to-day only to mention the differential diagnosis and must leave you to think out how each of the diseases can be distinguished from carcinoma. The differential diagnosis is from diverticulitis, an appendix mass, actinomycosis, tuberculosis, Crohn's disease, kidney swellings, an enlarged gall bladder, swellings of the liver (including congenital cyst and a Riedel's lobe), and an enlarged spleen. Carcinoma of the stomach or pancreas, carcinoma of the bladder, tumour of the uterus and ovaries must also be excluded. When a mass is felt per rectum tubo-ovarian abscess or pelvic abscess may simulate a tender carcinoma of the sigmoid.

I will now deal with treatment in principle only, as details of operative technique may well be left to the operating surgeon and Fellowship candidate. I am well aware of the dramatic success in the hands of some surgeons of the intraperitoneal resection with end-to-end anastomosis after preliminary drainage of the bowel by colostomy, but recommend to you the exteriorisation of the carcinoma with extra abdominal resection and anastomosis, (known as the Paul-Mickulicz's operation,) as safer and simpler.

The actual procedure adopted is dependent upon the degree of obstruction present at the time of operation. Laparotomy and colostomy is all that is safe in the presence of acute obstruction. The abdomen is opened by a right paramedian incision centred at the umbilicus, a hand is passed in and the site and extent of the growth determined. If it be in the left colon a transverse colostomy is performed, if in the right colon (an obstruction due to growth of the right colon is excessively rare) an ileostomy. Rodney Maingot and others consider the best type of ileostomy in these cases is to bring out a loop of terminal ileum, to cut across its summit and bring out the two ends separately so establishing immediate and adequate drainage. Ten days later the Paul-Mickulicz's operation is performed. In the case presenting with chronic obstructive symptoms, the bowel is cleared by daily enemata and the bulk of fæces reduced by prescribing a low residue diet. The diet should be high in protein, the patient's hæmoglobin brought up to over 80 per cent., and 16 grammes of sulphasuccidine should be given by mouth daily starting 48 hours before operation with a double initial dose. The abdomen is opened by a paramedian incision on the side of the lesion and a Paul-Mickulicz's operation performed. The steps in this operation are extensive mobilisation of the growth, and this is possible even in the case of a growth of the splenic flexure. The growth, as much healthy bowel on either side of it as possible, together with the posterior parietal peritoneum, blood supply and, most important, the regional lymph vessels and nodes are next delivered through a separate incision made at the lateral border of the rectus sheath. A 4-inch spur is formed by suturing proximal and distal parts of the loop together as far away from the growth as possible. The parietal peritoneum is sutured round these so that the top of the future spur lies just level with the skin and the laparotomy and colostomy wounds are closed. Four crushing clamps are then applied, and the exteriorised loop with the carcinoma at the summit excised

by dividing the two parts of the loop between the clamps. The patient is returned to the ward and, as soon as the wound is sealed by lymph, both remaining clamps are removed. A week later an enterotome is placed on the spur and tightened daily till it cuts through the spur and falls out of the colostomy. The fæcal fistula so left will usually need closure by a small extra-peritoneal operation before fæces will be passed entirely per rectum.

In the case of carcinoma of the cæcum a two stage operation will be required, first an end to side ileo-transverse anastomosis and 14 days later a right hemicolectomy.

In advanced cases with secondary deposits in the liver the maximum degree of palliation is achieved by resection on the lines indicated above. There are only very few cases where the growth is so extensive that it cannot be exteriorised, and it is only these who need suffer the indignity of a permanent colostomy. In inoperable growths of the cæcum an ileo-transverse anastomosis should be performed.

The post operative treatment is that of shock and blood loss by plasma and blood respectively. Dehydration must be prevented by intravenous glucose and saline, and paralytic ileus mitigated against by continuous gastric suction. Morphia gr. 1/6 four hourly should be given for the first 48 hours and an enema administered only after co-ordinated bowel sounds have returned and been heard with the stethoscope.

I have perhaps painted a rather optimistic picture and glossed over the failures in order to bring to your notice the greatly improved results of surgery at the present day, and to indicate to you how, when you are in general practice, you may help to make these results even better by early diagnosis. I have mentioned to you the main reasons for this promising trend, but have only had time to deal in an all too summary manner with the differential diagnosis and treatment. I have offered a plea to those of you who one day will specialise for the Paul-Mickulicz's operation as safer than intraperitoneal anastomosis, and if less dramatic and more tedious in achieving the final result, it is attended by a lower operative mortality and offers a cure to a higher percentage of the sufferers from this dread disease.

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Reviews

Textbook of Medicine. By SIR JOHN CONYBEARE. Eighth Edition. Livingstone. *Price* 30*s.*

THE appearance of seven editions in the eight years, which include the war years, gives a measure of the popularity of this textbook. It is easy to understand this popularity since it is brief and clear, yet comprehensive, well written and well printed.

When the book first appeared its aim was to provide the essentials of Medicine "within as small a compass as possible." It was intended presumably as an introduction to the study of Medicine for the student or as an "aide memoire" for the practitioner or student who already had a knowledge of Medicine. It still serves this purpose admirably although it has reached almost the admissible limit for a book of small compass. Sir John exercises great skill and restraint in keeping down the length of his own and his collaborators contributions and keeping them pruned and clipped to fit their planned environment instead of allowing the lush growth of more full-blown publications. What this book gives is the essentials and the facts: you must look elsewhere for fuller theories and "further details."

There have been two previous textbooks of Medicine which have been written or edited by Guy's men—Fagge's Medicine and Taylor's Medicine. Conybeare's textbook is in its own individual and different way a worthy successor to the others.

Materia Medica. By HALE-WHITE (revised by A. H. DOUTHWAITE). 26th Edition. J. & A. Churchill, Ltd. *Price* 14*s.*

THERE are many medical text-books which the student will close with a sigh of relief the day he qualifies and hope never to open again. Hale-White's "Materia Medica" is not amongst these. In spite of the factual nature of the subject, Dr. Douthwaite contrives to make it interesting reading, and it is full of information indispensable to the newly qualified house officer, and also to his more senior colleague.

The sections on therapeutics are of particular value. The 26th Edition is absolutely up-to-date, and contains important sections on the sulphonamides, penicillin, the new anti-coagulant drugs, and hormonal therapy. N. S.

Short Textbook of Midwifery. By G. F. GIBBERD. 4th Edition. Churchill. *Price* 21*s.*

EVER since the first publication of this book in 1938, the rejoinder, "It says so in Gibberd," has been unanswerable. It has established itself, certainly in this Hospital, as the standard textbook on obstetric practice for students and nurses learning or revising, and as a reference volume for post-graduates. It is so clearly based on clinical experience that one feels confident that in following it one is doing the practical thing as opposed to providing the theoretical answer. Such theorising as it contains is so rational, clearly sorted, scrutinised and balanced that midwifery becomes not a subject to be learn't, but simply a subject to be understood—and very simply.

This fourth edition is very much the same as the previous volumes, with a few modifications and alterations bringing it up to date. Everyone will be glad to know that the now famous words, "in 11,000 consecutive deliveries in an average group of patients at Guy's Hospital," still have their place in print. We trust that the author, rather than collect any more cases, changing that magic number, will turn to writing a similarly lucid textbook on Gynæcology. There is an urgent demand for such a work.
H. A. R.

Pulmonary Tuberculosis. By R. Y. KEERS and B. G. RIGDEN, with a Foreword by F. H. YOUNG. E. & S. Livingstone, Ltd. *Price* 17*s.* 6*d.*

THE authors have succeeded in presenting a fair, well-balanced and absolutely up-to-date account of Pulmonary Tuberculosis and its complications. The section on treatment is good and emphasises the importance of treatment of the patient as well as his lungs. Their views on collapse therapy are orthodox and sound and bear the unmistakable imprint of extensive practical experience. There are a number of well chosen X-rays to illustrate the text. This book should provide stimulating and profitable reading for the student. N. S.

Tuberculosis and Chest Diseases for Nursess. By G. S. ERWIN, M.D. Churchill, Ltd. *Price* 10*s.* 6*d.*

THIS is an excellent book. In the expansion of the Health Services the author believes that trained Nurses will have to take an important part. He therefore asserts that Nurses should be trained, not to the minimum standard but to the maximum of their capacity. This is an important consideration at the moment, when there is an idea rather prevalent that Nurses are being taught too much. Educated women will not be satisfied to be trained as Nurses unless they are also taught something of the diseases of the patients whom they nurse. This book strikes a happy medium.

It is written in considerable detail, both as regards the pathology and treatment of chest diseases; but the detail explained has mainly a practical interest for the intelligent Nurse who is really interested to know the value of pathological findings, X-ray reports, etc. The larger part of the book deals with pulmonary tuberculosis but there is a section on non-pulmonary tuberculosis and on other diseases of the chest.

We are very glad to add this book to our Nurses' library.

H. M. G.

A Text Book of Bacteriology. By R. W. FAIRBROTHER, M.D., D.Sc., F.R.C.P. Fifth Edition. William Heinemann, London. *Price* 17*s.* 6*d.*

AFTER sundry reprintings during the later war years, this well-known book now appears in its fifth edition. The author, now released from service activities, has had opportunity to make a thorough revision of the text and, in face of the twin difficulties of introducing much new matter and restraining the page growth of the volume, has made an excellent job of it. The chapters on Chemotherapy, Filterable Viruses and the Ricketssiæ are noteworthy examples. Throughout the whole of the sections on systematic bacteriology the author has also carefully introduced practically all the recent innovations in routine cultural work. On the same principle he has deftly included, in outline at least, most of the newly introduced ideas in immunology arising from better appreciation of the mechanism of bacteriological chemistry. In spite of all hazards he has fully maintained his originally declared intention of concentrating upon the application of bacteriological methods in the prevention, diagnosis and treatment of disease. Thus we have no hesitation in recommending this book to the medical student, undergraduate and graduate, as giving a remarkably complete and concise survey.

F.A.K.

An Introduction to Bacteriological Chemistry. By C. G. ANDERSON, Ph.D. Second Edition. E. and S. Livingstone, Edinburgh. *Price* 20*s.*

IT is unnecessary to emphasise the growing importance of chemical knowledge in the pursuit of bacteriological research.

The sulphonamides, penicillin and other antibiotics are the reward of such studies. Clearly no bacteriological teaching is nowadays complete without a survey from the chemical angle. Thus, in 1938, when the first edition of this text book appeared, based on lectures forming part of the course for the University of London Diploma in Bacteriology, it was most welcome. The author gave a concise review of the subject as it then stood. Now, after nine years during which many startling new lines of investigation have been opened, he has brought the story up to date. In order to keep the size of the book within reasonable limits, it has been necessary to assume that the reader has an elementary knowledge of both organic chemistry and bacteriology, but not beyond that of the usual M.B. course. Within these limits the new edition copes most adequately with such important subjects as bacterial growth factors, antibiotics, chemotherapy, industrial fermentations, immunochemistry and the mechanism of the antigen-antibody reactions.

Formidable headings these, but the advantage of the chemical angle is that from it comes, in many cases, explanation. This has for years been one of the great needs in bacteriology. To those who find interest in microbiology we would strongly recommend this book as being complementary to the usual bacteriological text books and well worth reading in conjunction with them.

F.A.K.

Minor Surgery. Ed. CECIL FLEMING, O.B.E., M.Ch., F.R.C.S. 23rd Edition. J. & A. Churchill. *Price* 14*s.*

THE Twenty-third Edition of this well-known book appears, now edited by Cecil Fleming. Ten years ago this book would have needed little introduction in this Hospital as it was widely read by senior students and constantly referred to by

those doing House appointments. Nowadays, however, there is a tendency to refer to the more specialised books on its varied contents.

It is a book primarily written for the H.S. in his everyday work and deals with a variety of subjects; bandaging and the sterilisation of instruments to genito-urinary surgery and the administration of anæsthetics. Nevertheless, in its 400 pages there is a fund of useful information, most of which is quite up to date although some would quarrel with the naive opening statement in the section of Shock, which then continues in a similar strain.

In a book of this kind it must be very difficult to decide what to include, especially in a subject such as fractures. Again, the decision as to when senior advice should be sought is a moot point. But on the whole it is a most useful guide to the general problems met by the H.S.

A.J.D.

"*Psychiatry (Theory and Practice) for Nurses.*" By H. C. BECCLE. Faber & Faber. *Price* 10*s.* 6*d.*

DR. BECCLE has provided the nursing student for her final state examination in mental nursing, with a textbook up to date, and comprehensive, with emphasis appropriately placed on essentials of what makes for a working knowledge to the nurse.

Packed into its 250 pages, one finds provided detailed structure of the nervous system (with helpful diagrams), a reasonable presentation of human development from babyhood in keeping with Freudian thought, a chapter on the needs of the child and reasons for his emotional shortcomings, intelligence estimation, other chapters on organic and functional conditions, and modern physical treatments, including mention of nitrogen shock therapy. Pre-frontal leucotomy information is sketchy however, considering that the book is intended for final examination study. Practicalities of post-operative treatment and management would have been very helpful.

Arising out of this one becomes increasingly aware as one reads, that, though the book in its subtitle is called "Theory and Practice for Nurses," there is much more of theoretical information than there are practical suggestions for management and treatment. Nevertheless, the book is a happy advance on psychiatric textbooks for nurses.

M.S.

A Manual of Tomography. By M. WEINBREN. Lewis. *Price* 45*s.*

DURING the last few years Tomography has been so far developed that it now occupies a well defined position in routine Diagnostic Radiology. This comprehensive book will be a valuable work of reference to the Radiologist, and of considerable interest to both the chest Physician and the general Surgeon. The many illustrations are on the whole of very good quality, and the variety of regions in which this particular technique may be employed will probably come as a surprise to many of its readers.

The only serious criticism is that the author compares the value of Tomography with normal X-rays, but does not mention other special investigations such as stereoscopy which might be of equal value.

T. H. H.

Practical Anatomy. By W. E. LE GROS CLARK, M.A., D.Sc., F.R.S., F.R.C.S. 1st Edition. Edward Arnold & Co. *Price* 25*s.*

THIS book is a manual of dissection written for the ordinary medical student. It is without excess of topographical detail and it eschews the burdensome minutiæ customarily found in works of this kind.

In the preface the author observes that many teachers have for some time felt that the attention devoted to the study of gross anatomy should be curtailed and that more regard than hitherto should be paid to the broader aspects of anatomical science. Few will dissent from this view or from the author's conclusion that in the overcrowded curriculum of to-day the aspects of anatomy with which the student should be chiefly concerned are those requisite in the usual methods of diagnosis, prognosis and treatment, and in the understanding of physiological and pathological processes.

At each stage throughout the book instructions are given to remind the reader to consider, as he goes along, the relevent parts of the skeleton, the X-Ray appearances

in life, the functions of the muscles, the action of the joints, surface anatomy and the like. The introduction comprises directions for practical study, some excellent advice on observing things as they are, and a reminder of the variability of human form and structure.

The text presents a plain, lucid and readable account of what the student should know. The illustrations are numerous and helpful. The author has succeeded admirably in his purpose and the book is one to be welcomed. G. M.

The Rhesus Factor. By G. FULTON ROBERTS, M.B. William Heineman, Ltd. *Price* 3*s.* 6*d.* pp. 46.

THIS book presents an account of the Rhesus Factor and its significance in clinical medicine. To the average student the Rhesus Factor is hidden by a cloud of mystery, and this little book can do much to dispel that cloud. In so far as such a subject can be dealt with lucidly, Dr. Roberts does so ; and so long as the standard text-books of medicine remain obscure on the subject, his book will be useful in any student's library. The clinical aspects are constantly borne in mind, the basic pathology in each chapter being illustrated and clarified by case reports.

T. E. J.

An Approach to Social Medicine. By JOHN D. KERSHAW, M.D., D.P.H., M.O.H. for Accrington. London: Bailliére, Tindall & Cox. 1946. *Price* 15*s.*

THIS is an attempt, we believe the first one, to give a complete summary of the new approach to the problem of Health which has come to be called Social Medicine. The author compares Society to the Body and deals with its Anatomy and its Physiology, and then with its Disorders and Disharmonies. The second part is a discussion on Health and Sickness in Society. First Medicine in Society, then The Social Problems of Health, and then two chapters on The Philosophy of Health. The author is widely read, writes pleasantly, and has made an earnest attempt to tackle a new, great, and difficult subject. We wish his book success and hope to deal with it at greater length in a subsequent issue.

T.B.L.

Correspondence

Treatment of Migraine with Urea

SIR,—In my letter to you, line 6, I stated that I had used Urea in doses of 10 to 20 g. daily. This has been incorrectly printed as gr., *i.e.* grains instead of grammes.

Yours, etc.,

A. H. DOUTHWAITE.

49, Harley Street, W.1.

SIR,—I can confirm Dr. Douthwaite's experience with urea as a remedy for migraine. I would put the successful cases at less than 5 per cent.

There are many types of migraine, but I have never been able to satisfy myself that it is more successful in some types than in others. Even if untreated, there are cases which clear up spontaneously and I have been inclined to think that when there is improvement, it might as well have been *post hoc* as *propter hoc*. Nevertheless, I shall continue to try it, to see whether it is effective in any particular type, such as that seen in patients with a definite allergic history.

It is worth bearing in mind that phenobarbitone, which certainly helps these cases, is a urea derivative.

I have a case at present with a strong family history of allergy, which is aggravated by urea. To use a Joadism, it all depends what you mean by migraine. I think some cases may be loosely diagnosed as migraine—in fact I am pretty certain. The text-book definition "A condition characterised by paroxysmal attacks of headache, usually with nausea, and often preceded by disorders of vision" might well include other causes of headache. A mild uræmia or even an alkalosis might have to be excluded. There is room for further investigation of migraine.

Yours, etc.,

H. M. S. T.

SIR,—Like Dr. Douthwaite I cannot call to mind the periodical in which the original article appeared on the subject of treating migraine with urea, but, if my memory serves me, it was discovered accidentally as a result of carrying out a urea-concentration test on a case of migraine. I tried it at the time on my laboratory assistant, but it never really had a chance to help him, as he would only take it when attacks were impending, and then he was rarely able to retain it.

The most interesting case of acute leukæmia, described in your issue of the 12th inst., easily beats the most rapid one I can remember which was of about ten days' duration. I remember this case particularly as one of the most brilliant examples of "Spot-diagnosis," by a present member of Guy's Senior Staff, that I have ever encountered. He and I were standing in the Surgery as take-in ward clerks or dressers when the patient, a boy of ten, was carried in unconscious. As the child was carried past he pointed at it and said, "Myeloid leukæmia." We followed the child in and pricked its finger. The blood appeared like pink tooth paste squeezed out of a tube. "My dear Holmes," I said (or words to that effect), "how did you do it?" "Quite easy," he replied. "Unconscious with conjugate deviation of the eyes—hæmorrhage into the pons. What would be most likely to give a child of ten hæmorrhage into the pons? Myeloid leukæmia." And there were 1,250,000 white cells per cubic millimetre.

Yours, etc.,

J. W. SHACKLE.

53, Green Street, W.1.

Sport

RUGBY FOOTBALL

GUY'S *v.* OLD WHITGIFTIANS.

(Played at H.O.P., Saturday, March 22nd.)

Result: Guy's 22, Old Whitgiftians nil

After a long absence from rugger owing to the treacherous weather the hospital had their first home game since meeting Royal Air Force early in January, and had no difficulty in defeating Old Whitgiftians by 2 goals and 4 tries to nil.

Whitgift had the advantage of the wind during the first half but Guy's did most of the attacking without, however, being able to penetrate the determined Old Boys defence. The Whitgiftians had the misfortune to lose J. D. Winston their right wing early in the game through injury, and although he returned a cripple it was obvious their side was disorganised. As it was, they carried out some good forward rushes but their threequarters were well marked by our backs.

Guy's led at the interval with a try by P. D. V. Harrett from a scrum, following a fine passing movement by the threequarters. With the wind in their favour, Guy's indulged in some open play, swinging the ball about with such freedom that few clubs would have withstood the onslaught. Tries came at frequent intervals through M. Hatton, D. N. H. Owen, A. De Villiers, B. Eksteen and F. Van der Westhuizen, two of which were converted by T. L. T. Lewis.

GUY'S *v.* LONDON SCOTTISH.

(Played at the Athletic Ground, Richmond, Saturday, 29th March.)

Result: Guy's 24, London Scottish 3.

Not for a long time have we seen a Guy's team knitted so well together as they were against London Scottish, whom they defeated by 2 goals, 2 dropped goals, and 2 tries to a penalty goal. It is safe to say without fear of contradiction that on this performance Guy's would have had a big say in the destination of the Hospitals' Cup had it been played.

London Scottish were outplayed. Never at any time during the game did they look dangerous, but on the other hand, Guy's forced the Scottish into false positions by skilful handling, sharp bursts, and good backing-up. Behind the scrum the hospital were far superior and it was delightful to watch the intricate manœuvres of H. Brunow, F. Van der Westhuizen and F. Le Clus. A word of praise must be given to W. Whamond in the unaccustomed position of scrum half for such a sound display.

London Scottish opened the score with a penalty goal by K. Downes. Thereafter Guy's assumed complete command. D. Le Clus went over for a try in the corner, and then a magnificent scissor movement between H. Brunow and F. Van der Westhuizen led to F. Le Clus crossing the line for T. L. T. Lewis to convert. Just before the interval, F. Van der Westhuizen dived over in

the corner from another good passing movement.

Following the interval when attacking strongly, Guy's took a big lead with dropped goals by F. Le Clus and H. Brunow, and finally D. Le Clus converted his own try which came as the result of a combined movement by F. Le Clus and F. Van der Westhuizen.

The hospital players proved conclusively that there is no justification for London Scottish in dropping the Guy's fixture for next season and the one after.

GUY'S *v.* RICHMOND.

(*Played at the Athletic Ground, Richmond, Saturday, 5th April.*)

Result: Guy's 5, Richmond 12.

For the second successive Saturday Guy's were the visitors to the Athletic Ground, and on this occasion were beaten by Richmond by a goal, a dropped goal, and a try to a goal.

Richmond had a strong side which included a few notable Varsity players, but they took a long time to settle down and it was not until the second half that their forwards were able to break through and open up the way for their backs. Meanwhile, Guy's had the better of the earlier play and went ahead with a try by K. R. Heber from a movement by H. Brunow and F. Van der Westhuizen by racing round to the posts after evading some half-hearted tackling. T. L. T. Lewis converted. Richmond drew level when their stand-off half, P. J. Osborne, was allowed to cut through unchallenged and M. A. Girling kicked the goal.

Following the interval the hospital were unable to prevent the opposing forwards breaking through and harassing our backs. There were many anxious moments and eventually a nice movement ended in D. J. W. Bridge crossing our line far out.

Guy's had several chances to score but many of the three-quarter movements were erratic and went astray through faulty passing. Eventually, M. A. Girling put the issue beyond doubt by dropping a good goal from the twenty-five yards line for Richmond.

HOCKEY

HOSPITAL CUP—SECOND ROUND.

(*Played at H.O.P., Wednesday, Mar. 12th.*)

Result: Guy's 3, K.C.H. 2.

The game was distinguished more for spirit than skill. Playing on a slippery, muddy and bumpy ground with inadequate umpiring, good hockey was impossible. We were the better side and should have won by a more decisive score.

SEMI-FINAL.

(*Played at H.O.P., Wednesday, Mar. 19th.*)

Result: Guy's 5, Middlesex Hospital 0.

We attacked strongly from the bully-off and Earl opened the scoring within the first five minutes. Throughout the first half we continued to press and Earl scored again from a melée. The Middlesex forwards had few chances to attack. When they did, Carton-Kelly and Danford at back were more than their match. In the second half, our forwards were served so many long clear passes, especially from Harris at left-half, that they would have been indeed ungrateful had they not taken advantage of them by scoring three more goals, one from Kelsey Fry, two from Vans Agnew (one from a short corner). This was the team's best performance this year.

HOSPITAL CUP FINAL

GUY'S *v.* BART'S.

(*Played at Motspur Park on March 28th.*)

Result: Guy's 4, Bart's 4.

Without Vans Agnew, who was playing for Scotland, the Guy's attack was seriously weakened. Even so, during the first half we looked like a winning team and at half time were leading 3—1. Our first two goals were put in by Earl, completing movements begun well in our own half. The third goal was an opportunist goal from Kelsey Fry. Bart's only goal in this half came from a penalty bully. The second half began equally well. Bart's scored a beautiful goal from a free hit near the circle, but we soon replied with a goal from Kelsey Fry completing a movement begun on the left wing. After this, playing uphill, Guy's began to tire. Bart's scored one more early in the half and then again, less than five minutes from the final whistle. Extra time provided tired, snappy hockey, but no goals.

Team—see below.

Replay: Guy's 3, Bart's 4.

In the absence of an available neutral ground this was played on the Bart's ground at Chislehurst. Our attack was stronger with the return of Vans Agnew and the only other change was the inclusion of Carter for L. D. Carton-Kelly, who had been called-up. Our side was sharper but Bart's also had a better side, including J. Dossetor, ex-captain of Oxford University.

Bart's began by scoring two quick goals in the first five minutes. After this setback, we controlled the game in the first half; reaching the turn, leading 3—2. But our goals were all scrappy, none of them coming from organised movements; Khong, Earl and Kelsey Fry were the scorers. In the second half we strove for the odd goal which would give us a winning lead, but it did not come. The defence, apart from Walker in goal, who was playing a very steady and safe game, became wearied and this led to many mistakes. Even so, it was not until the last five minutes that Bart's scored an equaliser.

Soon after the start of extra time, Kelsey Fry hurt his shoulder and was out of the game. Playing against 10 men, Bart's scored the deciding goal in the last 10 minutes of extra time. Guy's had a chance of equalising when they were awarded a short corner, but this was not converted.

Team : F. H. Walker, P. Danford, L. D. Carton-Kelly, J. B. Harris, E. A. Murray, R. A. Keable-Elliott, K. Y. Khong, P. S. Carton-Kelly, S. Earl, I. Kelsey Fry (Captain), D. V. Duckworth.

In the replay, N. Carter and W. Vans Agnew came in for L. D. and P.S. Carton-Kelly respectively.

FENCING

The club had increased its membership by last term, though not to the extent that was expected. The fixtures included matches against some experienced teams, R.M. Instructors, Deal, R.A.F. Records, Ruislip and Cambridge University. These were lost, the foil being drawn in the Cambridge match.

Success was achieved against London Hospital, University College, and Queen Mary College, and twice in foil matches versus Old Cholmelians.

A match against Imperial College was lost 16—9.

In the University trials, N. H. Porter came second in the foil and reached the final pool in the épee, while O. Couran came third in the foil, won the épee, and reached the final pool in the sabre.

J. M. Holden did well in the team in the first half of the term. I. A. W. Scott has proved himself a tower of strength in the later matches, and is to be congratulated on his performance.

This term the activities of the club have been somewhat damped by the cold spell, and the consequent need for moral courage in disrobing and facing, for the sake of sport, the arctic draughts which sweep the Pavvy Gym.

There have been a number of new members in spite of this.

Two matches were held, a foil match *v.* Queen Mary College, and a three weapon match *v.* Royal Naval College, Greenwich. Both were won. We hope to have two teams and a fairly extensive fixture list next term.

O. COURAN, *Hon. Sec., Fencing.*

Hospital Information, etc.

NOTICES

GUY'S HOSPITAL DENTAL SCHOOL.

Applications are invited for the following posts commencing 1st October, 1947 :—

DENTAL MECHANICS AND PROSTHETICS.

Half-time Assistant to Director of Dental Laboratories
2 Demonstrators for 2 sessions each
2 Demonstrators for 3 sessions each

DENTAL SURGERY.

2 Half-time Assistants to Director of Conservation Room
1 Demonstrator for 1 session
2 Demonstrators for 2 sessions each
4 Demonstrators for 3 sessions each
Administrative Dental Officer (Half-time

DENTAL DISEASES OF CHILDREN. 2 Half-time Registrars

PREVENTIVE DENTISTRY. 2 Half-time Assistants

DENTAL BACTERIOLOGY. Assistant Clinical Pathologist (Dental) Demonstrator

DENTAL HISTOLOGY. Demonstrator

Forms of application may be obtained from the Medical School Office and should be returned on or before Monday, 9th June, 1947.

Applications are invited from graduates in Dental Surgery trained at Guy's Hospital Dental School, for a Scholarship tenable at the Northwestern University, Chicago, commencing in September 1947. The Scholarship is valued at 500 dollars for tuition fees, etc.

Full particulars can be obtained from The Dean Medical School Office, Guy's Hospital, S.E.1. Closing date for applications is Tuesday, 13th May 1947.

DEPARTMENT OF SURGERY.

At 10.30 a.m. on Saturday, April 26th, there wil be a Clinico-Pathological Demonstration in the Anatomy Lecture Theatre.

On Tuesday, May 6th, there will be a further demonstration in the series "Operative Procedures" at mid-day in Theatre 2.

On Saturday, May 10th, at 10 a.m., Mr. A. Dickson Wright, M.S., F.R.C.S., will be conducting a departmental round in Queen Ward.

H. J. B. ATKINS,
Director of the Surgical Department.

NINETIES CLUB (GUY'S HOSPITAL).

Union of "Goblins" and "Contemporaries."

The Annual Dinner of the above Club will take place at the Trocadero Restaurant on Wednesday, May 14th, 1947, at 7.30 p.m., with Dr. B. W. Moss in the Chair, preceded by a meeting at 7 p.m.

Price of dinner £1 1*s.* 0*d.* exclusive of wine. Will any who entered Guy's in the 'nineties, who do not receive through the post a notice of this dinner, and would like to attend, please send their names and addresses to the undersigned.

E. B. DOWSETT, 12, Gloucester Place, Portman Square, W.1.

THE INNOMINATE CLUB.

The Annual Dinner will be held this year at the Trocadero Restauranr at 7 p.m. on Friday, 30th May, 1947. Price of Dinner, excluding wines, 16*s.* 6*d.* (in advance).

All desirous of attending, please communicate with the Hon. Secretary.

G. T. HANKEY, 89, Harley Street, London, W.1
Tel.: Welbeck 4777.

NINTH CONGRESS INTERNATIONAL COUNCIL OF NURSES TO BE HELD IN ATLANTIC CITY, U.S.A., MAY 10th TO 17th, 1947.

Miss D. M. Smith, O.B.E., and Miss Florence Taylor are shortly leaving for the United States. They have the honour to be chosen to represent the British National Council and the Sister Tutors Section of the Royal College of Nursing respectively.

We wish them *bon voyage.*

PASS LIST

CONJOINT BOARD.
FINAL EXAMINATION.

April, 1947.

Pathology.

P. O. G. Butler
J. M. Frisch
*J. M. Hall
E. Killey
J. L. Moffatt
J. B. Morrison
J. M. Palmer
W. J. St. E. G. Rhys
P. Sattin
D. J. R. Snow
A. J. De Villiers

Medicine.

*A. G. Atkinson
*J. B. Eades
*R. L. Edwards
*L. J. Evered
J. K. G. Grieves
*J. M. Hall
*C. D. Korn
J. L. Moffatt
J. M. Palmer
*P. Read
*C. J. Roux
P. Sattin

Surgery.

*J. J. Fingard
R. French
W. E. Macbean
D. M. Rahilly

Midwifery.

D. A. Ager
*J. H. Apted
*M. B. Couran
N. Davis
R. French
J. L. Hardman
G. E. Haward
K. M. S. Hume
M. G. Kaye
R. H. N. Long
J. T. Owen
B. J. Silkoff
E. H. O. Smith

* Have completed the Examination.

UNIVERSITY OF LONDON.
SPECIAL SECOND EXAMINATION FOR MEDICAL DEGREES.

March, 1947.

H. M. Baird
B. Bass
D. G. Bluett
A. G. Blyth
A. E. R. Buckle
J. C. Camac
J. C. B. E. Carreras
P. J. Cook
P. Dinmore
J. Foley
R. Goulding
R. C. Greenberg
T. S. Hart
J. M. Holden
J. W. Hughes
E. M. Hume
E. J. McGuire
M. J. R. Mackrill
I. J. MacQueen
R. C. Michell
R. C. Namth-Misir
R. J. Powell
A. M. Reader
I. Rocker
T. I. Rowland
P. S. B. Russell
P. A. Skinner
P. R. Sowerby
D. E. Sturdy
I. B. Thomas
M. G. Thompson
W. H. Watson
K. G. Worms

CONJOINT BOARD.
DIPLOMA IN ANÆSTHETICS.

December, 1947.

R. G. G. Jones
W. N. Vellacott

UNIVERSITY OF LONDON.
EXAMINATION FOR THE ACADEMIC POST-GRADUATE DIPLOMA IN MEDICAL RADIOLOGY.

PART I.

March, 1947.

J. E. M. Brown
J. C. Bulstrode
J. C. A. L. Colenbrander
M. J. R. Franks
J. M. W. Wells

ROYAL COLLEGE OF SURGEONS OF ENGLAND.
F.R.C.S.
FINAL EXAMINATION.

February, 1947.

P. G. Epps
G. F. Smart

UNIVERSITY OF LONDON.
EXAMINERS FOR MEDICAL DEGREES, 1947.

Forensic Medicine.—Dr. C. K. Simpson with Dr. J. H. Ryffel to act in an Emergency.

Medicine.—Associate Examiner: Sir J. J. Conybeare.

Obstetrics and Gynæcology.—Mr. F. Cook.

Surgery.—Associate Examiner: Mr. H. J. B. Atkins.

CHANGE OF ADDRESS

R. Boutwood, L.D.S., R.C.S., 2, Harley Street, W.1. (Tel.: Langham 2137 and 1936.)

E. C. Davies, F/O. R.A.F., 203168, No. 6 R.A.F. Hospital, Hassaniya, British Forces, Iraq.

G. P. Gibson, L.D.S., R.C.S., 41, West End Road, Ruislip, Middlesex.

PAPERS BY GUY'S MEN

Barber, H. W. Multiple tuberculides including the scleroderma-like form of Erythema Induratum. *Proc. Roy. Soc. Med.*, 1946–7, **40**, 245.

Bishop, P. M. F. Disorders of Sex as a manifestation of endocrine abnormalities. *Practitioner*, 1947, **158**, 295.

Broster, L. R. Adrenals in Sex. *Practitioner*, 1947, **158**, 307.

East, W. Norwood. Prostitution. *Ibid.*, 335.

Forman, L. Papulo-necrotic tuberculides. *Proc. Roy. Soc. Med.*, 1946–7, **40**, 248.

Stevenson, F. Harwood. The home consultant. *Lancet*, 1947, i, 532.

Symonds, Sir C. Pain in disease of the Nervous System. *Practitioner*, 1947, **158**, 354.

Thomson, L. C. Binocular summation within the Nervous Pathways of the Pupillary light Reflex. *J. Physiol.*, 1947, **106**, 59.

Visick, H. C. The teeth of the Kabyles. *Dental Record*, 1947, **67**, 59.

APPOINTMENT

Mr. W. Kelsey Fry, C.B.E., has been re-elected as a member of the Board of Examiners in Dental Surgery.

BIRTH

SHARP.—On April 3rd, 1947, at Purley Hospital, to Hilda (née Palmer), wife of G. E. Sharp—a brother for Christopher (John Alan).

DEATHS

HENSON.—On March 2nd, 1947, in Impendhle, Natal, William Warner Henson, M.R.C.S., L.R.C.P.

RAMSDEN.—On March 26th, 1947, in Oxford, Walter M. Ramsden, M.A., D.M., Johnston Professor or Biochemistry, University of Liverpool.

Eds. { D.H.F. / H.A.R.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

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PASSIM

THE signs and symptoms of Spring Fever appear in a hospital community as surely as they are to be seen in the outside world. There may be no " host of golden daffodils " to dance in the park, and the birdsong may pass unheard amidst the more powerful notes of distant traffic, but certain features still present themselves to prove that the season does not arrive unheeded.

The welcome sunshine, which makes somewhat erratic appearances, brings with it a resumption of the after-lunch siesta in the open air, when the fortunate may attempt to recline on seats, while others must squat in the dust where, once upon a time, the grass grew green and fair.

Through the windows of the Massage Department the inquisitive eye may perceive a fresh and added vigour in the wild antics of the patients who pursue those health-giving contortions designed especially for them by that hearty band of strapping womanhood—the physiotherapists. One feels sure that, within the hallowed confines of Shepherd's House, bigger and better quadriceps are being built whilst the deep kneading of fibrous nodules is being carried out with such unbounded zest that the offending lesion is being driven far into the depths of the couch on which the sufferer lies.

The nurses who flit like so many butterflies from the Nurses' Home to the wards look almost as radiant with the joys of life as their colleagues who, freed of the yoke of duty, make the return journey.

Perhaps the most noticeable effect of Spring on Guy's has been the confusion of spring-cleaning into which all corners of the hospital seem to have been plunged during the recent weeks. For a time entrance into the colonnade was blocked by an impressive array of ladders, planks, and white-coated artists who, with well-placed strokes of the brush, would dislodge the dust and resident bacteria of many years standing which adorned the roof of that famous arcade. On another occasion the sickly odour of distemper in the college would blend somewhat bizarrely with that of the ever-ready Vienna Steaks, with or without onions, while many a coat would show the scars of a brushing acquaintance with the wet paint on the walls.

The chief topics of conversation among the student body are plans for holidays and lurid descriptions of vivas recently attended at one of the University Inquisition Halls. The same elements of doubt as regards the parentage and species of certain examiners are once again expressed and the unfairness of the whole examination system hotly disputed.

So many persons seem to have spent weary moments recently listening for the sound of that little bell which always seems to possess that " See-you-again-in-six-months " ring about it, that the general level of cheerfulness is surprisingly high.

We learned recently that the invigorating atmosphere of the season has stimulated one well-known member of the hospital staff to such an extent that he may be heard pacing the long room of his department, whistling in uncertain tunes the current classic, " Open the door, Richard."

The Residents' Play which has been revived at last, was presented in the Physiology Theatre nightly from April 29th to May 2nd, and, with its usual humour and good tunes, ensured that most Guy's people within an accessible distance of the hospital, were afforded at least one very enjoyable evening's entertainment. We hope to publish a report of the play in a later issue of the *Gazette*.

Thus, with these lighter features added to our everyday life in this somewhat exacting world, we stand amidst the cold ashes of our last pipe, turn our faces to the wind, unroll our umbrellas and prepare to face the bitter onslaught, ironically called Summer.

On Thursday, May 1st, Dr. Geoffrey Marshall, who is retiring from his present position on the staff, held his last ward round. Very regretfully we say " Goodbye " and, on behalf of all our readers, wish him a well-earned and very happy retirement.

We are pleased to welcome back to the Hospital, Sir Charles Symonds and Mr. Eckhoff, who have returned from their visit to the Johns Hopkins Foundation in America and we look forward to meeting our visiting Specialists from the United States.

The Child Health Services

A Clinical Lecture delivered on 8th July, 1946

By R. W. B. ELLIS, O.B.E., M.D.

GENTLEMEN. If any of you should have pictured the child health services of this country as a neatly planned and constructed pyramid, surmounted by the Minister of Health uneasily impaled on the apex, I should like to disabuse your minds of this conception forthwith. The structure is more comparable to that of a vast, rambling country house, built over a period of centuries, and to which each succeeding generation has made characteristic additions. The floors are at different levels, communications between the various wings are devious or non existent, many of the rooms are filled with lumber, and skeletons are continually being discovered in disused cupboards. The grounds abound with follies, dower houses, and lodges in different stages of disuetude. During the present century, an increasing proportion of the main building has been taken over by various government departments, prefabricated structures have been added, and modern conveniences installed ; much still remains, however, in private hands.

Before considering the modern additions and future plans, it is worth while spending a little time on the earlier buildings, even though some of these are marked down for demolition. By far the oldest and most inconvenient structure is the block now labelled Central Administration. Antiquarians have discovered traces of Saxon workmanship in the basement devoted to Local Government, whilst the Norman oubliette is still in constant use for the disposal of troublesome memoranda. In the network of passages, many

of which are simply labelled " Pass to you, please," government officials are continually getting lost. An orphan presenting himself at the door may ultimately find himself the responsibility of any one of no less than seven ministries or of one of a hundred voluntary organisations. Whilst the Lords of the Admiralty, the War Office, and the Air Council usually know which babies they are expected to hold, the Ministry of Health, the Home Office, and the Ministry of Education frequently appear to be in doubt. Failure to recognise and define responsibility for the unwanted child may at first sight seem farcical, but it is only too liable to lead to tragedy, as exemplified in the recent O'Neill case. It is difficult to see how any comprehensive Child Health Service of the future can be efficient until the whole antiquated system of Local Government is overhauled.

To return to the rest of the building, there is little else that survives which predates the eighteenth century. Typical of their time, the eighteenth century builders showed a distinction and breadth of vision which puts much of the Victorian era to shame. Although some of their plans were not completed until more than a hundred years later, others are models of their kind at the present day. It was in 1769 that the first Infant Welfare Centre was opened in London by Dr. John Armstrong, and by 1781 some thirty-five thousand infants had been treated; it was said " that no charitable institution was established whereby so much good has been done, or so many lives saved at so small an expense." Owing to illness of the founder, lack of financial support, and public indifference, this pioneer effort was abandoned, and it was not until the twentieth century that the Infant Welfare Movement became firmly re-established. Captain John Coram, founder of the famous Foundling Hospital, which received its Royal Charter in 1739, was more fortunate. Distressed by the fate of the many illegitimate and unwanted infants who were found thrown on dung hills or abandoned in the streets, Coram shouldered a responsibility for them which had not even been contemplated by the State. Infants under two months of age were admitted to the institution and cared for until they became self supporting. Needless to say, accommodation was almost immediately inadequate to meet the demand, and the organisation suffered many vicissitudes and many abuses. These were multiplied during a short period during which government grants were obtained on condition of universal admission, and in 1770 the system of private support was re-established. At the present time the health and physique of the four hundred children in the Thomas Coram School bear comparison with those of any school children in the country.

During the nineteenth century, the Industrial Revolution introduced new factors which took an appalling toll of child life and health, before their consequences were even realised. The mushroom growth of the large cities, the new smoke pall, and the working conditions in factories combined to make rickets " the English disease." The infant mortality for the earlier part of the century cannot be estimated, as births were not notifiable until much later. Even in 1899 the infant mortality, *i.e.*, deaths under one year, was officially given as 163 per 1,000 births, which was undoubtedly an under-estimate. Following the destitution of the Hungry Forties, the call for child labour in the cotton and other trades reduced the standard of child health to its lowest level at a time when there was virtually no large scale organisation for child care. When compulsory education was introduced by the passing of the Education Acts of 1870 and 1880, it was estimated that in the London

area alone there were 50,000 children (10 per cent. of those attending school) who were found to be "too hungry to learn."

It would not be true to say that the smugness of the well-to-do Victorians in face of existing conditions was entirely unrelieved. There were notable exceptions among them, such as Lord Shaftesbury and Dr. Barnardo, both of whom worked untiringly to relieve the destitution and exploitation of children; both, needless to say, had to face bitter opposition. Lord Shaftesbury, who, following the death by suffocation of two small boys employed as chimney sweeps, had pleaded in the Lords for reform of the laws governing child labour, was attacked for "pitiful cant and pseudo-philanthropy," whilst Dr. Barnardo was no less bitterly attacked by certain religious bodies for accepting destitute children irrespective of their creed. The Churches were also active, but much of the work undertaken at first smacked rather of a sectarian than Christian motivation.

The public conscience was, however, gradually awakened by various means. Charles Dickens (to return to the simile of the country house) did much to show up the squalor of the back premises, and it is at least partly due to him that Oliver Twist, the poor-law child, is better housed, and that Sarah Gamp has become transmuted into the trim, efficient young midwife of to-day with a College and a Central Board of her own. Another notable event was the enquiry carried out by Dr. William Farr in 1867–9 in collaboration with the Obstetrical Society of London, which indicated that 50 to 75 per cent. of births in England and Wales were at that time attended only by midwives, and that these midwives were almost entirely uninstructed. Such a statistical enquiry, though having great influence on the medical profession and the subsequent training and registration of Midwives, made a less dramatic appeal to the public imagination than the trial and execution of Margaret Waters in 1870 for infanticide. This lady was typical of the professional baby-farmer of the day, whose occupation consisted essentially of disposing of illegitimate and unwanted babies; her particular technique was the combination of laudanum and starvation, which she had practised successfully for years before the accumulation of bodies in the streets near her home attracted the attention of the police. Her trial was followed some years later by that of Mrs. Dyer, whose method differed only in that she strangled the infants and threw them into the Thames. The Society for the Protection of Infant Life, which was founded in 1870, estimated that the mortality of infants entrusted to baby-farmers was between 60 and 90 per cent. It is of interest that although the evils of baby-farming were well-known, having been repeatedly exposed in the medical press, Lord Shaftesbury had been unable to move the government to take any action until the trial of Margaret Waters brought matters to a head.

One other event which took place in the latter half of the nineteenth century requires special mention, since it was to have far-reaching effects. This was the establishment of organised Health Visiting in 1862 by an association of ladies in Manchester and Salford. As Dr. G. F. McCleary has pointed out, health visiting was a peculiarly English contribution to the child welfare services, and has since been carried throughout the world. The Child-Health Visitor is now one of the most highly trained of social workers, and may be said to be mainstay of the infant welfare movement.

The beginning of the twentieth century found the country ripe for the rapid development of the child health services. This was partly due to a

growing body of informed and humanitarian opinion which was making itself felt, and partly to a concatenation of circumstances which had changed complacency in high places to a state bordering on alarm. Compulsory notification of births had brought to light an infant morality rate so high that it could no longer be disregarded. Compulsory education had brought togeher the child population, and shown for the first time the high proportion of children who were physically or mentally defective, verminous, or ineducable due to malnutrition. Recruitment for the Boer War had demonstrated even more clearly the lamentably low physical standard of the young adult population, which it was realised could only be remedied in the future by attention given to health in infancy and childhood.

Development of the child health services has occurred concurrently along a number of different lines. The more important of these are :—

1. Antenatal care and improved midwifery. Statutory training, examination, and registration of midwives. Instruction of midwives in care of the newborn.

2. Provision of meals or supplementary rations for expectant mothers.

3. Health visiting, including domiciliary visits after notification of birth.

4. Provision of infant welfare clinics and consultations.

5. Provision of clean milk and vitamin supplements for infants.

6. Establishment of school medical and dental services.

7. Provision of school meals. The Education (Provision of Meals) Act, 1906, first made this possible by local authorities, and the facilities have been greatly extended by the Education Act of 1944.

8. The organisation of school treatment and consulting centres.

9. The setting-up of Care Committees by local education authorities.

10. The establishment of special schools for blind, deaf, mentally defective, and crippled children.

11. Care of illegitimate, orphan, and destitute children, and regulation of adoption.

12. The establishment of juvenile courts for dealing with cases of juvenile delinquency, with facilities for psychological examination.

13. The protection of children suffering from neglect or cruelty, or found to be in moral danger.

There is no clear-cut division between the " voluntary services," *i.e.*, those organised by independent bodies, often employing salaried and trained workers, and those provided by Local Authorities or the State. In general, the tendency has been for services to be started by voluntary initiative, and subsequently to receive grants from the local health or education authorities ; recently an increasing number of these have been taken over and controlled by the local authorities, though even then some degree of voluntary aid may be retained. A good example of this is seen in the organisation of the Infant Welfare Service. Originally Infant Welfare Centres were started either by a local voluntary committee, who were entirely responsible for control and for the raising of funds, or alternatively were started by local authorities acting on their own initiative, often in co-operation with a voluntary committee. At the present time there are still independent infant centres, centres under voluntary control

but receiving financial support from the local authority, and centres (now the majority) which have been set up by, or passed into the control of, local authorities.

The protection of children from neglect or cruelty, on the other hand, is still very largely in the hands of a National voluntary body, the N.S.P.C.C., which employs a very large staff of trained and salaried social workers throughout the country; the services of the Society can be called on by the police, local authorities or private individuals for the investgation of cases, and the advisibility or otherwise of bringing a prosecution against the parents or guardians of the children concerned rests with the Society in most instances.

The principal child health services may be summarised very briefly as follows :—

1. *The Maternity and Child Welfare Service.*—Under the Maternity and Child Welfare Act of 1918, Local Authorities were empowered to provide a comprehensive service covering antenatal care, childbirth, and infant welfare. It should be emphasised that the legislation is still only permissive, and whilst some progressive Local Authorities have provided a most efficient service, others have lagged very far behind. The Infant Welfare service includes the provision of infant welfare clinics, where infants can attend for weighing and supervision by the superintendent, medical examination at longer intervals, and where milk and vitamin supplements can be obtained at special rates; in addition, health visitors (in country districts the health visitor may be the district nurse) should be available for domiciliary visits after a notification of birth has been received, and in other cases as required.

In many centres, as for instance the Salomon centre, antenatal care, domiciliary midwifery, health visiting, and infant welfare are carried out from the same centre; this has the great advantage of integrating the whole service, and ensuring close co-operation between midwife and health visitor.

Children under five, who have not started school attendance, are included under the Infant Welfare Service. Administratively, therefore, pre-school children are the responsibility of the local health authority and ultimately of the Ministry of Health. Should, however, a child of three be admitted to a nursery school, he automatically becomes the responsibility of the Ministry of Education and is no longer entitled to attend an Infant Welfare Centre.

2. *The School Medical and Dental Services.*—By successive Education Acts culminating in that of 1944, the education authorities have undertaken increasing responsibilities for the health and dental care of schoolchildren. It was at first intended that the school medical service should provide regular medical inspection only, and that children requiring treatment should be referred to their own practitioner or to an existing clinic. It was soon found, however, that the majority of minor ailments, of which pediculosis, ringworm, and impetigo were the most prolific causes of absence from school, could be dealt with more promptly and efficiently at a school treatment centre, with a school nurse in attendance. Cases requiring more skilled investigation and treatment are referred to consulting centres, often the appropriate clinic of the local hospital.

Even in the school medical service some element of the voluntary system is retained, and Local Education Authorities are required to set up a voluntary Care Committee for welfare work amongst school children, and to assist in carrying out medical recommendations.

The provision of special schools for physically and mentally handicapped children is also included under the school medical service.

3. *Voluntary Services.*—Voluntary and independent bodies are still responsible for a multiplicity of activities connected more or less directly with child health. Apart from the voluntary hospitals (amongst which the children's hospitals have for the last century made a particular appeal to private benefactors), such bodies include a substantial proportion of the existing child guidance clinics, orphanages, children's homes, adoption societies, and youth movements. The Invalid Children's Aid Association deserves particular mention as the co-ordinating body through which convalescence is most readily obtained, whilst the National Council for Maternity and Child Welfare incorporates this and some eighteen other voluntary bodies.

During the past few years there has been an increasing tendency to co-ordinate voluntary effort, in an attempt to diminish inefficiency and overlapping. The Charity Organisation Society (now The Family Welfare Association) has played a prominent part in such co-ordination, whilst a watching brief has been kept on finance by the Charity Commissioners. It is easy to criticise voluntary organisations, whose life is often financially precarious and whose policy liable to be governed by the dead hands or personal whimsies of individual benefactors. At the same time, it must be realised that in the past legislation has usually been enacted only when the pioneer efforts of independent bodies have proved its need and practicability; that many of the essential aspects of child care are still only handled by voluntary organisations; and that in planning the Child Health Service of the future it would be disastrous if the accumulated experience and initiative of the independent bodies were not adequately utilised.

Lady Loosepaine

A MIRROR FOR NURSES

By H. St. H. Vertue.

"A FOOL sees not the same tree that a wise man sees." The public sees not the same nurse that a physician sees. In fact it does not see a nurse at all but only an image of its own creation, an infantile creation at that.

At a railway station the other day I picked up Mr. Anthony Armstrong's book, *The Garden*, a short work very carefully written and far above the commonplace. It told of a man who lay upon his bed sick unto death and longed to pass out into the garden that he loved. Presently he did pass out and obtained all the desire of his heart: one knew then that he was dead.

But in the room with him there was a nurse, a starched person. She kept fidgeting him with her sewing. She rebuked him too. She was motherly, but she had little sympathy or real understanding. When he asked her to restore freedom to a bee that had blundered in, she put it out but did so stupidly. It was painfully clear that the man had quite as much desire to escape from the nurse, as she was conceived to be, as from anything else in life; and since this conception did not correspond to a real nurse, what could it represent?

There was a moment, one noted, when he relented : it was when she bent over him to arrange a pillow and he caught a smell of sweat. This made her seem healthy and human and lifted her above " the soulless hospital reek." (Iodoform ! Mr. Armstrong is at least thirty years out of date here). But why soulless ? That souls grow white in the performance of these duties has once been said : that there is no soul in them is a contention that cannot be entertained at all. What, again, did he really mean ?

The sweat-glands secrete fatty acids, Nature's " vanishing cream," and three of them, caproic, caprylic and capric, are soluble in the secretion of Bowman's membrane, stimulate the olfactory cells and produce a sensation of smell. This smell is sexually stimulating : hence all the coyness about it.

Besides, it's fun to say
" The favourite is sweating,"
For in the usual way
The word is deemed upsetting :
Though all Debrett were wet
With obvious exudation,
One might not say, " They sweat,"
That would be " perspiration."

A.P.H.

Even Mr. Armstrong calls the secretion of the sweat-glands " perspiration."

The meaning of this incident is, then, that with the smell of sweat sex accrues to the nurse, who was previously without it. For " soulless hospital reek " read " sexless reek." The image that was seen is now clear enough. It was not the likeness of a real nurse but something arising out of the mind, something maternal but not agreeable, restrictive, sexless in the ordinary sense and not very intelligent ; and it is an image like this, variously tinged or ameliorated, that is generally adopted instead of the reality.

Nam nil aegrins est quam res secernere apertas
ab dubiis, animus quas ab se protinus addit.

On the stage or in a story, so far as I know, this is the version that is always presented.

You will have guessed that, having consumed Mr. Armstrong's book, I was content to put it back and go away in the usual manner without paying for it ; but you will be wrong : it is in my library now. Full of thought on the subject I then set forth with the agreeable object of visiting Furvus Felix Psychologistes, and after dinner,

When body gets its sop and holds its noise,
And leaves soul free a little,

I sought from him a name for this unprepossessing figure. After a little prompting he came out with the neat phrase, " The Stern Mother." There and then I was able to point out to him an embodiment of this very thing, which had been looking down at us from his mantlepiece all the time. A part of it represented the gentle figure of the Virgin Mother with the Infant, but the head was adorned with the mural crown of the Great Mother, Cybele, and the face was anything but agreeable, was in fact actually forbidding. This strange work of art was a fusion of the two different conceptions of the Mother, the one mild, the other oppressive. With raucous horns and Phrygian flutes the ancients would draw forth the Great Mother in her car to scare the minds of the vulgar ; but the conception is inherent in humanity and a much milder

form of that terrifying deity can still be evoked to-day by so benign a symbol as the nurse. It seems odd, but it is so.

Ingratos animos atque impia pectora vulgi!

In the last century, which was much more romantic in temper than this, there was another conception of the Nurse, that of an ideally Good Woman. There was an instance of it in a picture that made a great stir in its day, "Is it nothing to you, all ye that pass by?" But now that the wind is perpetually in the East, the romantic ideal has withered away and the less pleasant notion characteristically remains. One must admit that this representation was not strictly true, but it was nearer to the truth than the Stern Mother.

It must often be wondered why the patient's gratitude to his nurse appears so short-lived or shallow. The explanation is now discovered. While she is there, human proximity may make him appear grateful, but afterwards he soon forgets all about her. Perhaps on leaving he presses some gift upon her, gloves, stockings, chocolates or whatever the time allows; but yet he afterwards takes his way and does not think of her again.

Be she fairer than the day,
Or the flowery meads of May;
Be she meeker, kinder than
Turtle-dove or pelican,

it is all the same. At the time she may have been a comfort and a strength; afterwards her memory merges into that of the illness itself, a thing to be forgotten, or only remembered as something unpleasant. For all the kindness she may have showered upon him, for all her devotion to duty on his behalf, her indifference to fatigue, monotony or his own troublesomeness, for all her patient attention to detail and her careful study of his peculiar needs, yet has he never seen her truly as a woman and rapidly he allows her real self to be eclipsed by an image. It may be taken almost for granted that the vivid osphresiolagneiac incident (to give it its technical name) in the story was not founded on invention but on experience, that the writer had in fact been nursed; yet see what a picture he draws of the nurse!

There are one knows exceptions. Some never forget. Some families adopt a nurse as a friend and may even try for years to forward her interests for good. Yet I believe it is more often parents and spouses that show a deep and permanent gratitude than patients themselves. It follows from this that nursing is an altruistic profession, inasmuch as devotion therein meets with little reward. Therefore one would expect nurses on the whole to be women whose character is well above the average; and this really is the case notwithstanding the fact that there are bad nurses and bad nursing, and great variation between the products of different schools. One may go still one step further: the supply of such women being limited, a first-rate body of nurses and a very large body of nurses cannot co-exist, a thing worth remembering.

For the same reason a patient seldom marries his nurse. Medical men and students often do and rarely have cause to regret their choice, but patients scarcely ever fall in love. It would be most natural to expect some of them to do so, but they do not, because the real woman is ousted by the maternal image. To the unfettered imagination of our older poets it seemed that when tenderness and skill succoured manliness and strength, love was the almost certain requital. Sir Eagar or Sir Gryme might go forth against

Sir Gray-Steele and return from the combat somewhat the worse; but the Lady Loosepaine would come forth from a green arbour and insist on the need for easement.

> She was cladd in scarlett redd,
> And all of fresh gold shone her heade,
> Her rudd was red as rose in raine,
> A fairer creature was never seene.

She would lead the wounded knight to her chamber, escorted between two fair ladies, undight his bloody armour, wash him with warm water from a silver basin, and with a fine knowledge of antiseptics and an equally fine disregard of expense, apply essential oils to his wounds. Her range of treatment went beyond our own.

> The Ladye, lovesome of hewe and hyde,
> Sett her downe by his bedside;
> Shee layd a sowter upon her knee,
> And thereon she playd full lovesomelye,
> And her two mayds full sweetlye sang.

Why do our nurses never sing or play to their patients nor the juniors make sweet moan? Many can sing beautifully I know. How dull we are! How insensitive to the claims of Art! And this at a time when Medicine is becoming more and more aware of a psychic origin for illness!

Needless to say, on the second encounter Sir Gray-Steele would be worsted; and the victor, returning possest of his lands, would be accorded a royal welcome by the Earl and Countess, whose only child the Lady Loosepaine was, and be given her hand in marriage. And thus they lived and made a good end, (but not, one may mention, before Lady Loosepaine had born ten children).

Yet we shall be in safer hands if we turn for guidance to England's Arch-poet rather than to the simple-minded author of Egar and Gryme, true poet though he was. In the third book of the Faërie Queene Belphœbe finds Prince Arthur's squire where he lay in a deadly swoon, caused by the wound he received in settling the account of the three fosters. She rescues him, bears him to her Pavilion in the woods and nurses him with devotion.

> "Ah God! what other could he do at least,
> But love so fayre a Lady that his life releast?"

is the poet's reflexion. But Belphœbe did not apply the sweet cordial that might cure a love-sick heart.

> "That daintie rose, the daughter of her Morne,
> More deare than life she tendered, whose flowre
> The girlond of her honour did adorne:
> Ne suffred she the Middayes scorching powre
> Ne the sharp Northerne wind thereon to showre;
> But lapped up her silken leaves most chayre,
> When so the froward sky began to lowre;
> But soon as calmed was the christall ayre,
> She did it fayre dispred and let to florish fayre.
>
> Fayre ympes of beautie, whose bright shining beames
> Adorne the world with like to heavenly light,
> And to your willes both royalties and reames
> Subdew, through conquest of your wondrous might,

With this fayre floure your goodly girlonds dight
Of chastity and vertue virginall,
That shall embellish more your beautie bright,
And crown your heades with heavenly coronall,
Such as the Angels wear before God's tribunall ! "

It is a function of great poetry to tell us how to live, to express ideas, which can be fairly called moral ideas, in all the beauty of poetic form. Did men and women but drink more freely of this fountain of wisdom and truth, they would learn more about themselves and guide their lives better than they do.

Maternal love and sexual love blend but are distinct, maternal love being calmer, less expressive, but often more enduring, more in harmony in fact with a life bestowed on the tending and care of others. There must also be a difference between amateur and professional nurse. A single episode of nursing might well end in a passionate love, but a series of such emotions would be disastrous. Then too there are duties to be done of an intimate kind, washing, feeding and so forth, which bring the nurse to a maternal level; for these are things that mothers do for their children. One might truly say then, drawing a metaphor from astronomy, that a nurse's sex, while she is nursing, is shifted to the maternal end of the spectrum. This gives her dignity, an absolute necessity, especially in wards full of patients.

Therefore we array her in pale blues, soft greys and tender lilacs; therefore a shining white apron bespeaks her chastity and the glory of her hair is partly hidden by a snowy cap. Then the Sisters, in their dresses of deeper hue and caps with lace-trimmed edges, achieve a dignity and grace that match the eighteenth century, the only appearance that I know that does so to-day. Those that think that an overall should be enough for a nurse show therein little sense of the psychology of nursing and none at all of the poetry. Tawdry adornments, aids to a spurious beauty, purchased at the chemist's for so much a box, are eschewed by her. Familiar chat with soldiers or students, turning the hospital grounds into the likeness of an esplanade at some second-rate seaside resort, is not indulged in. Silliness and light behaviour appear in her especially foolish. All this is while the nurse is nursing: at other times she is as other women are, a fact to be mentioned because sometimes it is forgotten.

Between the nurse and her patient there is a partnership. If both do not set forth together, the journey to health may be hampered, and the end delayed or never reached. To use an overworked word there must be co-operation, but it is one in which the nurse predominates because by virtue of her training she knows the better what to do. She is not restrictive, and if she were to be so, she would not be a good nurse.

Out of this material the popular mind has constructed an image which it identifies with the crude conception of the Stern Mother. A remarkable result is that the Nurse has never been justly celebrated in play or story. No Juliet has appeared like a winged messenger of heaven on the balcony of the Nurses' Home, no Romeo made blessed his rude hand by touching hers at the Nurses' Dance. " Good-day and happiness, dear Rosalind," has not yet greeted her in forest glades on her day off, nor a quatrain of enchanted lovers met—well, let us say, at Honor Oak, if not at the Duke's Oak. Yet she seems tempting material, with the twin currents jostling in her soul, with hands ever engaged in tender tasks, with the background of high culture that a great hospital affords and with first-hand knowledge of birth and death, love and

fear, pain and the triumph over pain. Only a nurse herself, a medical man who understands, or a genius able to transcend the common notions of the day could do it as it should be done. But where is one or another of these to be found?

Meantime, what is she like? A good place to look at her is in a room where a number has gathered together to listen to music. Under these circumstances the social mask drops off and the face assumes a perfectly natural expression, whether its owner be listening to the music, lost in reverie or lapt in soft slumber after a tiring day. The predominating expression is one of kindness. Indeed it would be difficult, I believe, to find in any other assembly so great an appearance of amiability. Add also to this a look of honesty and candour, a bodily habit that is strong, healthy and plump rather than lean, weakly or haggard and hands that are short, firm and practical, rather than long, tapering or dreamy, of if long, muscular and capable of a good grasp. There are as many handsome girls in nursing as in any other occupation, lending good looks to the picture that is formed in the mind of the whole; but there shines out of this pictured face a beauty of its own that comes from within, the beauty of a good spirit. Turn again to Colin Clout, who sang An Hymne to Heavenlie Beautie.

> So every spirit, as it is more pure,
> And hath in it the more of heavenly light,
> So it the fairer bodie doth procure
> To habit, in and it more fairly dight
> With chearefull grace and amiable sight.
> For of the soule the bodie forme doth take:
> For soule is forme, and doth the bodie make.

Too ideal a portrait? No! Drawn from life, from the life of a hospital where nursing has reached a pinnacle of success. For make no mistake: the nursing of Guy's is now one of the most famous and successful things about her and one least affected by the war. Besides, Narcissus was a youth and not a girl. "If ladies be but young and fair, they have the gift to know it."

The shifting of the nurse's sex while she is nursing, though both right and necessary, has been a great source of trouble to her. Our fathers, who were as timid about sex as ourselves about sentiment, vaguely apprehended that there was something unusual about her, but being quite unable to think clearly on the subject, confused her with the only woman that they knew in whom the sex was modified, though the modification is quite different, that is with a nun, no doubt helped to their mistake by the ancient association between hospitals and religious orders. From this error sprang a thousand ills, the female discipline night and day, the "home" that was no home but an institution where sisters ruled, the night-nurse locked in behind an iron gate, invasion of the nurse's own room by petty rule and regulation, uniforms stiff, cumbersome and unattractive, mortification of the flesh by over-work, poor food and reluctant recognition of illness, a system of passes to go out at night, holy obedience, none knowing where she might be sent or when or why, the chill voice of authority, the soured spinsters that this grim regime produced, revenging themselves on the young for their own frustration—these and many other things and the spirit that lay behind them were the cause of the slump in nursing. It has been a long battle against this harsh and sterile system, as the sun battles against the cold winds of spring, and nowhere can it be called summer yet. There is no doubt, however, that Guy's has for

long been among the most liberal hospitals nor that Miss MacManus has been a doughty champion of the nurse. Therefore the slump has not been felt much here. Elsewhere desperate measures are proposed to make up the shortage, such as the recruitment of children (virtually), of part-time workers or poorly educated girls, things to which we should lend no countenance. Up to the present too public attention has been paid only to rates of pay and hours of work, steps very necessary but representing merely the industrial outlook. The cause of the shortage of nurses does not really lie here but in the need for a more philosophical view of the matter.

Certainly the remedy is not to be found in obscurantist notions about limiting the education of the nurse, offspring mainly of old and rather silly masculine fears about the opposite sex. Can any woman be too well educated? Her fault, if she has one, lies in the direction of mental myopia. In my view the privilege of a nurse in training should be approximately that of an undergraduate, and that of a trained nurse, a person who can carry out responsible and complicated duties and manage a ward of men or women double or treble her own age, that of a graduate. Of women it may be truly said that the more you ask, the more they give, and the more you expect the more they perform. A large life, a broad outlook, an ample freedom: who shall deny that the harvest of such things would be a fine breed of nurses?

Correspondence

Flowers in the Park

SIR,—Now that the air-raid shelter has been removed from beneath the centre lawn in the Park and lawnmaking combined with other gardening activities are being undertaken by professionals, we feel that we would like to express our thanks to Miss Addiscott who so successfully grew flowers on this desolate site during the war.

Did one see such flowers at Guy's before the war? We doubt it. Miss Addiscott, in her struggle with high mounds of dead leaves and dried stalks in autumn, the chronic smoke from the chimney and vandals marching over her beds, has demonstrated to us all that flowers of merit *can* be grown at Guy's. We hope to see a continuation of flowergrowing at Guy's, because we feel that such an addition to the prospect is good for both patients and staff alike, but let us first say "Thank you, Miss Addiscott."

We are, Sir,

H. B. FENN.
G. HASLEWOOD.
AGNES SHORE.
L. C. THOMSON.

Guy's Hospital, S.E.1.

Hypnosis in Dentistry

SIR,—In view of the publicity recently given to Hypnotism, both in the National Press and the "British Medical Journal" (12.4.'47), I should like to bring to the notice of your readers an interesting case of my own.

The patient, a boy of sixteen, complained of severe pain during the drilling of an upper molar tooth. In order to continue with the excavation of the cavity with less discomfort, I injected 2 c.c. of 2 per cent. novocain solution, but found that the pain was still present.

A further 2 c.c. were injected, this time by a demonstrator, yet the tooth was still too sensitive to work on.

We decided to defer the operation until the following week, when owing to the fact that the tooth was just as sensitive, I obtained the boy's consent, and official sanction, to procure anæsthesia by Hypnosis.

The advantages obtained by operating in the mouth under these conditions are: (1) anæsthesia is deep and good (2) salivation can be controlled, (3) the patient can keep

the mouth open for any length of time without a mouth-gag, (4) there is complete post-operative analgesia, (5) there is complete amnesia in a large percentage of cases.

Needless to say the whole operation took me almost half the usual time, and when the patient was awakened he asked me when I was going to " do his tooth," as he had felt nothing and remembered nothing.

Paradoxically I have also completely removed the effects of a Mandibular nerve block ten minutes after it had taken effect.

Yours, etc.,
LEONARD BECKER.

Dental Department,
Guy's Hospital, S.E.1.

Review

Child Health. Edited by ALAN MONGRIEF, M.D., F.R.C.P., Nuffield Professor of Child Health, and WILLIAM A. R. THOMSON, M.D. London: Published on behalf of " The Practitioner," by Eyre and Spottiswood. 1st Edition. Pp. 254. *Price* 14*s*.

MORE and more doctors spend their time caring for the healthy child, but until comparatively recently they had no text-book. Professor R. W. B. Ellis edited one while he was at Guy's, Professor Craig of Leeds University has written another. Now Professor Moncrieff and Dr. Thomson have produced an attractive " Practitioner Handbook " on the subject. We suppose that the fashionable obsession with the term " Child Health " explains the title. In fact we have been presented with an extremely useful, readable, and practical book about the prevention of illness in children. There are also helpful chapters on physical and mental defects, child psychiatry, nutrition, etc. This neat volume deserves to be widely read and probably will be. P.E.

Hospital Information, etc.

NOTICES

DEPARTMENT OF SURGERY.

On Tuesday, May 13th, at 12 mid-day, there will be a further demonstration in the series " Operative Procedures " in Theatre 2.

At 10 a.m. on Saturday, May 10th, Mr. Dickson Wright will be conducting a Departmental Round in Queen Ward.

On Saturday, May 24th, at 10 a.m., there will be a Clinico-Pathological Demonstration in the Anatomy Lecture Theatre.

During the latter half of May, there will be an exhibition in the Gordon Museum illustrating diseases of the Testis and Epididymis.

H. J. B. ATKINS,
Director to the Surgical Department, Guy's Hospital.

GUY'S HOSPITAL LAWN TENNIS CLUB.

The season this year officially opened on Saturday, 3rd May, with the trials at H.O.P. We extend a particular welcome to all those new members who have just returned from the forces.

This year we have three new red courts. These, with the three grass courts, should make the booking of courts unnecessary; if, however, it is found to be necessary a scheme will be instituted later.

K. M. HUME,
Hon. Sec. G.H.L.T.C.

PASS LIST

POST-GRADUATE DIPLOMA IN PUBLIC HEALTH.

March, 1947.

W. E. Greenwood
E. R. Hodgson Todd
J. A. MacDonald
K. R. D. Porter
R. Tilley
R. West

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

F.R.C.P.

W. N. Mann
C. Hardwick

M.R.C.P.

April, 1947.
J. S. Stead

July, 1947.
T. M. L. Price

OXFORD UNIVERSITY.

March, 1947.

GENERAL PATHOLOGY & BACTERIOLOGY.

J. G. Armstrong
J. Taylor

PHARMACOLOGY & THERAPEUTICS.

J. G. Armstrong
J. Taylor
J. M. D. Hooper

CHANGES OF ADDRESS

D. C. Light, M.R.C.S., L.R.C.P., Boyton Cottage, Claremont Ave., Esher, Surrey.

I. S. MacLeod, M.B., B.S., 30, Derby Hill Cres., Forest Hill, S.E.23.

Major I. E. Zieve, R.A.M.C., British Military Hospital, Paris, British Forces in France.

APPOINTMENTS

J. F. Lockwood, M.R.C.S., L.R.C.P., L.D.S., R.C.S., appointed Assistant Honorary Dental Surgeon to St. George's Hospital.

EDS. { D.H.F.
H.A.R.

GUY'S HOSPITAL GAZETTE

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PASSIM

THE holiday season has arrived, and each week sees a steady decrease in the number of students on their respective firms, whilst registrars are obliged to work harder and harder, fulfilling the duties of absent colleagues in addition to those on their own well-filled time-tables.

The average busy doctor gets little opportunity to take time off from his industrious round and very often the summer seasons pass, leaving him regretting that, as a student, he had not taken full advantage of the opportunities for vacation afforded him at that time. When the golden chance does arrive, however, what does he do?

With a gesture of complete joyful abandon he flings aside his stethoscope, picks up his bucket and spade, wife and children, and runs as far away from a telephone as his meagre income will allow. For a few carefree moments he prepares to seek a hotel life instead of a hospital existence, and is promptly called up to the gentleman in number twenty-four who has chosen that particular time and date to strangulate his hernia, or occlude one of his coronary arteries.

Wherever the medical man goes he is always a doctor and everyone always knows it. The lounge-haunting hypochondriac who has lain steeped in spa water for as long as she likes to remember, will surely corner him and unfold to his sympathetic but weary ears the innermost secrets of her unfortunate life of malady. The rubicund, retired colonel will, without the slightest doubt, spend evenings telling him that doctors are not really necessary if people would only adopt the simple procedure of either swimming in the Serpentine every Christmas Day, or sitting on the Khyber Pass for fifty years with a bottle of whisky in one hand and a man-eating tiger in the other.

He learns countless remedies for the most bizarre complaints and, when his brief sojourn in what was intended to be a place of rest is ended, he returns to the medical fold, a confused and tired mortal, tells all his colleagues what a wonderful time he has had, and tries to look fit.

There are some more fortunate members of the fraternity who have private havens of retreat and there, far from the madding crowd, they sit patiently with rod and line and catch pneumonia, or spend a riotous hour or two trying to rescue their youngest offspring who has contrived to fall head-first down a ravine and is lying in a nest of red ants with his trousers on fire.

Thus it would seem that, unless he be a rich man, the doctor must either face the crowd or pay the price of nature wherever he should choose to spend his leisure days and, until some future State scheme reserves a string of the Outer Hebrides for their weary servants, the problem of holidays is going to continue unsolved.

We take this opportunity of wishing all those members of the staff about to embark on a vacation, a quiet night and a safe return.

The Scientific Approach to Surgery in America

By NILS. L. ECKHOFF, M.S., F.R.C.S.

YOU will all know of the scheme, sponsored on this side by the Clothworkers' Company, whereby two members of the Staff of Guy's will be selected each year, for the next five years, to go to Johns Hopkins Hospital "in exchange" for two members of the Staff of Johns Hopkins, who will come to Guy's. I need hardly say how delighted and honoured I felt when asked to go as the first surgical representative, with Sir Charles Symonds as first medical representative.

Some of you may have been to the States before, but it was my first trip, and I must say that I was amazed by all I saw and heard. I have called this talk "The Scientific Approach to Surgery in America." You may not regard any clinical work as scientific owing to the many variables, but I think the Americans' approach gets much nearer to that definition than we do in Britain. There are many reasons for this difference. 1. Each teaching school has whole time Professors in the Chief Clinical Departments, with several other whole time workers, and many house officers. 2. Each Department has its own laboratories, and many research workers. Thus in addition to research in the Department of Pathology, there will probably be pathological research in the Departments of Surgery, Medicine, Obstetrics, Gynæcology, Pædiatrics, and even Psychiatrics. 3. There is frequent interchange of opinion between workers in the same and in different departments of the hospital. Staff conferences are of daily occurrence, each department having one or possibly two per week. 4. There are numerous Society meetings at which people from different hospitals can exchange opinions. Annual meetings may last several days, with hundreds attending. 5. The population is so big, and the hospitals are of such dimensions that a worker in a special field seems to be able to get unlimited material. 6. As a result of these many factors, new ideas are rapidly propagated throughout the country, and are quickly checked and counter-checked.

I have not made it clear that there are also many part-time workers in the hospitals, both in the wards, operating theatres, and out-patient departments.

The operating lists are very impressive, and a big general hospital may well have fifty operations in one day, including all the specialties. There is therefore much for the visitors to see, and visitors are numerous, both from other American clinics and from clinics abroad. This all adds further to the rapid exchange of information.

Blalock's Operation.

Nobody can visit the Surgical Department of Johns Hopkins without being immediately fascinated by Dr. Blalock, and the operation he has devised. This is a clear instance of the application of the lessons of the research laboratory to the operating room. Dr. Blalock had in 1938 anastomosed the subclavian artery to the pulmonary artery (in dogs) in an attempt to produce pulmonary arteriosclerosis. He later anastomosed the subclavian to the aorta in experimental work on co-arctation (atresia) of the aorta. With his experience of these procedures and from conversations with Dr. Park and Dr. Taussig of the Children's Department, he developed what is now called Blalock's operation for pulmonary stenosis.

In pulmonary stenosis sufficient blood does not reach the lungs to be adequately oxygenated, and the patient is markedly cyanosed. The sobriquet "blue baby" is today well-known throughout America. Direct anastomosis between the aorta and pulmonary artery does not seem practicable, though this possibility has not been finally discarded. The first operations consisted in anastomosis between the innominate artery and one branch of the pulmonary artery. Today the subclavian is usually used, and occasionally the carotid. Use of the carotid or innominate may be followed by cerebral softening on that side, and is naturally best avoided.

The whole pathological picture is known as the tetralogy of Fallot, consisting of:—

1. Pulmonary stenosis or atresia.
2. Interventricular septal defect.
3. Dextroposition of the Aorta.
4. Right ventricular hypertrophy.

Other abnormalities in the vascular arrangements in the chest may be present (or other defects elsewhere).

Work still continues on injecting opaque substances into the heart with a view to getting X-ray shadows, which will help in the preoperative study. Thorium Salts, which have been used, are thought to be rather dangerous, but work continues with other compounds.

Other important preoperative studies include passing a catheter through an arm vein into the different chambers of the heart, and measuring the cardiac output, the 0_2 content of the arterial and venous blood, and that of the pulmonary vein, the pulmonary artery flow, the systemic flow, the oxygen saturation, etc.

Having decided by X-ray studies if there is a right or left aorta, the chest is entered through an anterior incision on the opposite side. The azygos vein is divided, and the great vessels dissected out very thoroughly. The pulmonary artery is identified in the lung root. The subclavian (provided it is long enough) is divided between clamps as far out as possible. Its cut end is brought down and sutured to a transverse incision in the clamped pulmonary artery by end-to-side anastomosis. The great moment is the removal of the arterial clamps, and it is quite rare to see any troublesome bleeding.

Excellent anæsthesia is given by specially trained nurses, and continuous electrocardiographic tracings are taken by another assistant, while an artist, from the school of medical art, draws pictures all the time. These are available for future study, if desired.

At a meeting of Hopkins alumni the day before I arrived, the operation was televised, so that the many doctors could watch in other rooms, many floors away. The apparatus set up by the N.B.C. was said to have cost 30,000 dollars. I am told the reception was very good.

After the operation, the colour of the patient is much improved, and there is usually a marked improvement in functional tests, but Dr. Blalock has not yet formed a final assessment. He does one of these operations almost every day, and some of his assistants have done cases. 300–400 have had the operation, and I am told that there are 600 waiting to be done—they come from all over the world.

Other Operations on large Vessels.

Ligature of a patent ductus arteriosus was first successfully performed by Gross of Boston in 1938. Since that time the operation has been performed repeatedly both in this country and in the States, and is not considered to be remarkably difficult. Blalock does not cut the ductus, as Gross does, but relies upon a purse-string suture at each end, two through and through mattress sutures, reinforced with umbilical tape.

Operations have also been performed for coarctation of the aorta. In this condition the aorta is narrowed at or near the position of the obliterated ductus arteriosus. In spite of the development of a collateral circulation, the blood pressure is high in the upper limbs, and low in the lower limbs. There is danger of cerebral hæmorrhage, thrombosis, heart failure, rupture of the aorta, or bacterial endocarditis. Although these patients are not so incapacitated as those with pulmonary stenosis, relief of the condition is desirable, if it can safely be done.

Crafoord in Sweden and Gross have succeeded in excising the stenosed area, with end to end anastomosis. The aorta can be clamped for a period sufficiently long to do the operation, in view of the previously developed collaterals.

A further remarkable piece of work is the attempted relief of portal hypertension by surgery. A question in the recent F.R.C.S. paper on this topic left many candidates guessing. Portal hypertension may be taken to include cirrhosis of the liver, and what is usually called Banti's disease. In these conditions the pressure in the portal vein rises, venous radicles between the portal and systemic systems dilate, producing hæmorrhoids, dilate œsophageal veins, etc. Serious bleeding may occur from the œsophageal varices sufficient to threaten life.

An attempt is therefore made to divert the portal blood to a large vein in the systemic system. The obstruction may be in the liver itself, in the portal vein, or in the splenic vein. Intra-abdominal venous pressure readings taken at the outset of the operation help to define the point of obstruction. 100 to 110 m.m. of water is taken as normal. A high superior mesenteric venous pressure indicates a block in the liver or portal vein, or possibly in the superior mesenteric itself. A low superior mesenteric venous pressure and a high pressure in the coronary vein indicates a block in the splenic vein, and presupposes that the coronary vein joins the splenic, which it apparently does in a fair proportion of individuals. A low superior mesenteric and coronary venous pressure indicates splenic vein thrombosis, with a coronary joining the portal.

In the last group of cases, splenectomy alone should suffice, but in the others the choice lies between direct anastomosis between the portal vein and inferior vena cava, or if this is impossible, between the splenic vein (after splenectomy) and the renal vein, with or without nephrectomy. The anastomosis may be by means of a vitallium tube (Blakemore) or by direct suture anastomosis (Blalock). Unfortunately the anastomosis may become occluded in the spleno-renal group, but Blakemore has not known this to occur in the porto-caval group, no doubt owing to the higher venous pressure obtaining there.

Blakemore also believes that in cirrhosis hæmatemesis and ascites may occur as a result of depressed liver function alone, as estimated by prothrombin deficiency in the blood. He argues that the bleeding is due to the lowered

prothrombin time, and that these cases should be treated medically. In cases of cirrhosis with good liver function, portocaval shunt is indicated. In cases of cirrhosis with portal hypertension and poor liver function, medical treatment to improve liver function must be instituted first.

Liver Function Tests.

This necessarily brings us to a discussion of liver function tests. I attended an interesting symposium on the liver, which was notable as the whole meeting was organised and conducted by the students of Cornell University. Papers were read by a physiologist, a chemist, a physician, and a surgeon. Immediate sound records were taken so the students could hear the lectures again, immediately if they wished. I also attended another talk on liver function, given by a chemist at one of the weekly staff meetings at Johns Hopkins. A great many tests may be used, some of which I had never heard of. I was impressed how conversant surgeons seemed to be with medical, pathological, and physiological processes.

The following tests are used in an endeavour to study liver function :—

1. The albumin globulin ratio.
2. The cephalin-flocculation test.
3. The thymol turbidity test.
4. The prothrombin time.
5. The carbohydrate tests, intravenous galactose being considered the most satisfactory.
6. The cholesterol ester ratio.
7. The bromsulfalein test.
8. The alkaline phosphatase estimation.
9. Hippuric acid synthesis.
10. The colloidal gold test.

It is realised only too well that these tests have their limitations, but by using several of them in a particular case a composite assessment of liver function may be possible.

Blakemore (a Hopkins graduate now attached to that amazing Columbia Medical Centre in New York) is in addition doing very stimulating work on aneurysms. Aortic aneurysms he treats by passing a fine wire into the aneurysm through a needle, and then passing an electric current through the wire to produce thrombosis. Aneurysms of limb arteries are treated either by repair of the sac (Matas' endoaneurysmorrhaphy) with the help of vitallium tubes, or by excision and vein graft, either inside a vitallium tube, or with small vitallium cuffs at each end. He has had some fine results, and says the vein graft stands up well to arterial pressures. It was interesting to meet Dr. Matas, a pioneer in arterial surgery who, though well advanced in years, attends and takes part in the discussion at Surgical meetings, and in much loved and revered by all.

Vein Ligation in the Treatment of Thrombosis.

All surgeons are terrified of the sudden pulmonary embolism which will carry off an occasional patient after the most successful operation. It is generally agreed that the fatal clot comes from the leg veins, most often from the calf veins. Unfortunately the development of the clot, and its later loosening and liberation into the blood stream are often quite unheralded,

but where a small warning embolism occurs, or where there is tenderness in the calf veins, many surgeons in America practise ligation and division of the (superficial) femoral vein, just distal to the profunda femoris. Any clot present is removed from the vein. They hold that this is usually sufficient to prevent further embolism, and is of no disadvantage to the patient. They go further and state that if there are indications that one vein needs tying, the contra-lateral vein should also be tied. Some even tie both veins before operation, especially in elderly patients. In certain instances the main femoral, the iliac vein, or even the inferior vena cava has been tied.

Ligation of the femoral vein apparently produces minimal complications. At the Massachusetts General Hospital it had been done in 1,518 patients up to October, 1946. In 458 this was a prophylactic procedure in patients over 65, with one fatal embolus, whereas in a control group of 458 patients there were 26 fatal emboli, 11 of these in cases of hip fracture. Ligation of the inferior vena cava naturally carries more complications—quite alarming early vasospasm which may be relieved by sympathetic block, and persistent œdema, requiring elastic stockings.

Anticoagulants and other methods.

Other surgeons are using Heparin and Dicoumarol in the treatment of thrombosis. Gordon Murray, of Toronto, who first introduced Heparin, holds that if a patient is adequately treated with anticoagulants following pulmonary embolism, the chances of survival are excellent. Ochsner disguishes between thrombophlebitis and phlebothrombosis. He holds that in thrombophlebitis the clot is due to inflammation of the vessel wall, is white or mixed, and adherent. In phlebothrombosis clotting is due to increased coagulability of the blood, and venous stagnation, the clot is red, and easily detached. Phlebothrombosis can be minimised by gentle handling and speeding up the circulation, but if it should occur is treated by vein ligation.

Thrombophlebitis may be superficial, and of small moment, or deep, when a " white leg " is produced. This phenomenon, he believes, is largely due to reflex arterial spasm, and is treated by paravertebral lumbar sympathetic block, and early mobilisation. He claims rapid improvement in the fever, and the swelling, so much so that 70 per cent. of the patients were out of hospital in 4 to 8 days after the commencement of the treatment. When we think of the many weeks usually spent in bed by these cases, this is an outstanding advance.

Vagotomy.

Section of the vagus nerves, at or about the level of the diaphragm, in order to abolish the neurogenic secretion of gastric juice was started by Dragstedt in about 1943. To-day hundreds of cases have been done by surgeons up and down the land, and in one short month I attended four discussions on the subject.

Dragstedt holds that gastric juice will digest all living tissue, even including the gastric mucosa, but that this does not happen normally because—1, the continuous gastric secretion (Carlson) is neutralised by the duodenal secretions (Mann and Williamson). 2, the secretion poured out by the ingestion of food is neutralised by the food. But excessive secretion of gastric juice will produce ulcer (Wangensteen). This excessive secretion, present in most ulcer cases is neurogenic in origin. Secretion occurring at the sight of food is also neurogenic, while there is a further secretion as long as food remains in the stomach, which is hormonal in origin. Section of the vagus nerve will

not abolish the latter, but will, by interruption of the reflex arc, stop the neurogenic secretion. Experimentally, in the dog, the isolated stomach will secrete 2,500 c.c. of juice (and the dog will die of hypochloræmia, alkalosis and dehydration unless special steps are taken). If the vagus nerves are now cut, the secretion drops to about 300 c.c. (and the dog may be able to withstand this loss).

The vagus nerves may be cut above the diaphragm (by excising the eighth rib, and entering the chest) or below the diaphragm, through an ordinary abdominal approach. A more complete operation can probably be done by the former route, but the gastric lesion cannot be inspected, and an early cancer may be missed.

Postoperative studies show that the large gastric secretion of ulcer patients can be reduced to more normal levels. Histamine and alcohol test meals are usually used to study gastric secretions, and in ulcer cases will produce a greater flow than in the normal. This flow is due to the chemical stimulus. An insulin test is used to study the neurogenic secretion. 20–30 units of insulin injected in a fasting patient should lower the blood sugar to 30 mg. per cent. in 45 minutes. This hypoglycæmia stimulates the vagus centre. Increased gastric secretion at 45 minutes indicates that the vagus is still able to conduct impulses. The insulin test is therefore used to determine if any vagus fibres have been left undivided.

Apart from the effect on secretion, section of the vagus nerves diminishes the tone and the peristaltic activity of the stomach. The chief postoperative complications are gastric retention and dilatation, and troublesome diarrhœa. The former may be modified by postoperative gastric suction (which is commonly used in all gastric surgery in America) but may require gastroenterostomy. The cause of the diarrhœa is not known, but may be due to fermentation of food held up in the stomach. Ulcer pain is immediately relieved by vagotomy, and bleeding is apparently cured. In most cases objective evidence of healing can be obtained, even in gastrojejunal ulcers.

There are many who are not so enthusiastic about this operation as its author, Dragstedt. They feel that the complications are sufficient to make it a major procedure, that it should always be combined with gastroenterostomy or a large Finney pyloroplasty, and that not enough is known of the cause of the diarrhœa, or how vagus section modifies the function of other viscera, or the protective pain impulses from the abdomen generally. But the great experiment of vagotomy is fairly typical of the way things happen in America.

Biochemistry.

One of the most striking differences between practice in England and practice in the States, is the tremendous value they place on biochemical investigations. The following investigations are frequently used in what might appear to be simple surgical problems :

Estimations of :—Serum Amylase, Serum Bilirubin, Serum Calcium, Carbon dioxide combining power, Serum Chloride, Serum Cholesterol, Creatinine, Nonprotein Nitrogen, Urea, Serum Phosphatase Activity (Alkaline and Acid), Inorganic Serum Phosphorus, Serum Potassium, Serum Protein (Total) Albumin, Globulin, Serum Sodium, Fasting Sugar Glucose, and Uric Acid.

The significations in changes from the normal reading is indicated by charts which are available to the student and nurse and is here included.

PHYSIOLOGICAL DATA

Determination	Normal Amount in Fasting Blood		Pathological Conditions in which Changes May be Encountered in Adults
	Adults	Children	
Amylase, Serum	80–280 mg.* % reducing substances		High : Acute pancreatitis, parotitis
Bilirubin, Serum (Van den Bergh)	0·2–0·7 mg. %	Same	High : Liver disease, biliary obstruction, hemolysis, pernicious anemia (jaundice may be present)
Calcium, Serum ..	9–11 mg. % 4.5–5.5 m. eq./l.**	Same	High : Hyperparathyroidism, vitamin D overdosage, rapid bone destruction, high serum proteins Low : Hypoparathyroidism, rickets, osteomalacia, celiac disease, sprue, nephrosis, and hypoproteinemia due to any cause, nephritis with uremia. (Tetany may be a symptom)
Carbon dioxide combining power	55–65 vols. % 25–30 m. eq./l	45–60 vols. % 20–26 m. eq./l	High : Vomiting, overdosage of sodium bicarbonate, diseases of heart and lungs (especially emphysema) Low : Acidosis of diabetes, uremia, or starvation ; loss of alkaline secretion in diarrhœa or fistula ; hyperventilation due to salicylate poisoning, brain disease or anoxia
Chloride, Serum	100–105 m. eq./l.** 585–620 mg. % (NaCl)	Same	High : Chronic hyperventilation, over dosage of ammonium chloride, sulfonamide poisoning Low : Addison's disease, acidosis of diabetes and starvation, nephritis with uremia, excessive vomiting, several acute infectious diseases, compensatory to high serum bicarbonate
Cholesterol, Serum ..	150–250 mg. %	120–280 mg. %	High : Diabetes mellitus, nephrosis, biliary obstruction, pregnancy, hypothyroidism, zanthomatosis Low : Pernicious anemia, hepatitis, cirrhosis, inanition, acute febrile infectious diseases, hyperthyroidism
Creatinine	1–2 mg. %	Same	High : Chronic nephritis
Nitrogen, Nonprotein (NPN)	25–35 mg. %	Same	High : Nephritis and other forms of renal failure, Addison's disease, cardiac failure, intestinal or urinary tract obstruction, severe toxic and febrile conditions, dehydration, severe hemorrhage (especially gastro-intestinal)
Urea	10–20 mg. %	Same	Low : Acute hepatic insufficiency, occasionally in nephrosis and starvation
Phosphatase Activity Alkaline, Serum	2–4.5 Bodansky Units	4–14	High : Increase bone formation, active rickets, osteomalacia, Paget's disease, hyperparathyroidism, diseases of the liver (especially biliary obstruction)
Acid, Serum	0·5–2·0 Gutman Units		High : Carcinoma of prostate with metastases
Phosphorus, Inorganic, Serum	3·0–4·5 mg. %	4–5 mg. % (5–7 mg. % under 1 year)	High : Hyperparathyroidism, nephritis with uremia, administration of Vitamin D Low : Rickets, osteomalacia, increased CHO utilization, hyperparathyroidism

* There is greater variation and less significance of these values in children.

** Milli-equivalents per litre.

PHYSIOLOGICAL DATA—*continued*

Determination	Normal amount in Fasting Blood		Pathological Conditions in which Changes may be encountered in Adults
	Adults	Children	
Potassium, Serum ..	3–5 m. eq./1** 12–20 mg. %	Same	High : Addison's disease, heat cramps Low : Familial periodic paralysis
Serum Protein (Total) Albumin	6–8 gm. % 4·0–5·5 gm. %	5·6–7 gm. % 4–5 gm. %	High : Dehydration myxedema, changes in albumin and globulin Low : Albumin : Nephrosis, Nephritis malnutrition including gastro-intestinal disease, pernicious anemia, cirrhosis loss of protein in hœmorrhage, burns, and effusions
Globulin	1·5–3·0 gm. %	Same	High : Globulin : Multiple myeloma, sarcoid, lymphopathia venereum, many chronic infections
Sodium, Serum	140–146 m.eq./1** 320–340 mg. %	Same	High : Water deprivation, certain adrenal cortical tumours and renal disturbances Low : Addison's disease, heat cramps, acidosis of uremia and diabetes, vomiting, diarrhœa, hypoproteinemia
Sugar, Glucose, Fasting	70–100 mg. %	Same	High : Excitement, cold, anoxia, anœsthesia, diabetes mellitus, certain tumours of adrenal and pituitary Low : Starvation, severe liver damage, hyperinsulinism, Addison's disease, pituitary cachexia
Uric Acid	3–5 mg. %	Same	High : Renal insufficiency, gout, leukemia

** Milli-equivalents per litre.

It was difficult, in a short visit, to form a reasonable conclusion as to the importance of all these tests, but either we in England have not paid enough attention to the significance of biochemistry in medicine, or the Americans have stressed it too much. In particular great stress is placed upon the protein exchange of the individual, and the relationship between Serum Albumin and Globulin is thought to be highly important. Hypoproteinemia is discussed at great length. Whereas we have heard little about its signification in this country, a recent American paper quotes no less than seventy-three references. It appears that hypoproteinemia may be present in an amazing number of surgical conditions. It is particularly noticeable in postoperative states, in severe burns, chronic ulceration, and in shock. It is said that the attention to this deficiency is of great importance to the patient's well-being. In treatment it is not sufficient to use serum, plasma, or blood, but the diet must be supplemented with high protein-containing substances such as skim milk powder and Amigen. Amigen is a hydrolysate of casein and pancreatic tissue given intravenously, and is very much used both in medical and surgical conditions.

J. E. Howard of Johns Hopkins (and others) have done very interesting work on total intravenous feeding. On the average 12 grams of nitrogen and 1,900 calories were administered daily, that is, 100 grams Amigen and 375 grams glucose in 4,500 c.c. water. Sodium chloride intake varied from 4·25 to 8·5 grams daily. Great care is taken to render all fluids sterile, and to introduce the needle by a sterile technique. When intravenous feeding is

used for more than two or three days, vitamins are added in the following proportions :—

Thiamin HCl	5 mgms.
Ascorbic Acid	50 mgms.
Nicotinamide	75 mgms.
Calcium pantothenate	5 mgms.
Vitamin K (hykinone)	2 mgms.

Sterile potassium chloride 3 grams has also been added to each day's intravenous intake in all cases treated in the past six months.

Protein intake and output is studied carefully, and great stress is laid on whether the patient is in a state of positive or negative nitrogen balance. Total intravenous feeding has been carried on for several weeks.

The most interesting observation from a surgical point of view is that under total intravenous alimentation intestinal movements appear to cease, and washing from the colon reveals little except a rapidly diminishing number of organisms. This is quite clearly of tremendous value in the treatment of cases that have had operations upon the intestinal tract, or for the closure of fæcal and other fistulæ connected with the intestinal tract. It is also said to reduce postoperative discomfort due to " gas pains." If, however, the tiniest amount of fluid is given by the mouth, as for example in swallowing a couple of pills, intestinal movements immediately start, and intestinal juices are poured out in large quantities. It would seem clear that this adjunct treatment will have many indications in surgery and medicine, and would well repay careful study by someone here, particularly if casein hydrolysate can be obtained in this country.

Sympathectomy.

A great number of sympathectomies are still being done in American hospitals. This is, no doubt, partially a result of the excellent work which is being done by White and Smithwick of Boston, and the book they have written on the subject. I did not discuss the matter in detail with any of the American surgeons, and I imagine that they realise as well as we do that the results, at first promising, are somewhat short-lived. If one can give a person with a threatening gangrene of the leg a few extra years of comfort, one is obviously doing a good deed. Similarly, no doubt if one can reduce the blood pressure for at least a period of time, one may give the patient many useful years.

I was very interested in the work done by Richter on skin resistance tests in sympathectomised individuals. Skin which has been denervated conducts electrical impulses much more readily than in normal skin, and he is able, with quite a simple electrical device, to map out extremely accurately those areas that are denervated. The reaction appears to depend upon vasodilation of the skin vessels. He finds that he can often tell by the pattern which surgeon did the operation, in other words, surgeons tend to have slightly different ideas as to the exact amount of the sympathetic chain they are removing. He also finds that the denervated areas shrink as time goes on, which is what one would expect. The test is done both before and after operation, but I was not clear that it was of any great help in determining the value of the operation in any particular individual.

Richter, who works in a research laboratory in the psychiatric department, is also doing and has done many hundreds of feeding experiments on rats. The condition of his rats and the cages that they occupy must be seen to be believed. Everything is absolutely spotless, and the rats have an exercise chamber like a miniature treadmill, which is also required in some of the experiments. At the moment he is conducting experiments on selective feeding. The substances to be tested are placed in inverted U-tubes, in liquid form, and the rats are very selective in taking what is required to keep a balanced diet.

In the pathological research laboratory, Dr. Guy has been working on tissue cultures for twenty-five years, and I regret to say that I did not discover his laboratory until the last day, when he was absent. His wife kindly showed me how the cultures are made, but I did not have sufficient time to discuss the whole subject with them.

These are just a few of the examples of the sort of things that are going on in America to-day. It is clear that if we wish to emulate them we require very much greater facilities for research, and very many more people to execute that research. Most of us unfortunately find our time fully occupied in routine treatment of the sick.

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Correspondence

Honours and Awards

SIR,—Will you permit me to reply to Mr. M. E. N. Smith? He says :—

> "Medicine in the best and traditional sense has no service to render to the State; its service is to MEN, and thus the State owes it nothing." (*The capitals are mine.*)

I feel certain that those lines were never penned by a gynæcologist. I also note Mr. Smith's initials, with interest.

What does he understand by "the State"? Who constitute "the State"?

Is it not the population as a whole? The men and WOMEN who pay rates and taxes, who queue for pineapples, who go to the pictures, to Wembley, to Wimbledon and to the Dogs?

If medicine traces and eradicates an epidemic, is that no service to "the State"? Would "the State" owe it nothing for its services?

Did the surgeon who operated on Mr. Churchill render no service to "the State"?

Recently I had a discussion with an apparently intelligent foreman on the Government's schemes for nationalisation and asked him "Where is all the money to come from?"

"From Government Funds," he replied. "And where does the Government get it from?" "From the State," said he. "And where does 'the State' get it from?" He was quite nonplussed until I suggested that it came from him and me in taxation and that we, in fact, *are* "the State."

Any service medicine renders to "the State" is a service to every individual, and service to the individual is service to "the State."

If Mr. M. E. N. Smith will ponder this great truth he will begin to realise the width of its application.

I am, etc.,

THE VILLAGE DOCTOR.

Brookwood,
Surrey.

Honours and Awards

SIR,—It is always satisfying to air one's prejudices with gusto, and this form of self-indulgence frequently has the added virtue of providing entertainment: one can feel grateful to M. E. N. Smith, for his letter on Honours and Awards (*Gazette*, 5th July) while refusing to swallow some of his more indignant fulminations.

But while he detects a wistful note in the opening letter on his subject he leaves his readers in no doubt as to the vigour of his own compensatory aggression.

Are the motives of doctors who examine proposers for life assurance really so unmentionably base? Without their services no insurance company would dare offer terms of comparable liberality and so perhaps the best form of personal investment at present available to the individual of modest means would be beyond his reach.

Are the awards given to senior members of the profession who undertook whole-time war service so utterly undeserved? Might it not be suggested, with no less truth or at least no more prejudice, that by contrast the standard of leadership displayed during the war by some of those other "acknowledged leaders of the profession" was strangely reminiscent of the celebrated Duke of Plaza Toro?

Let us instead retain our objectivity. I am sure Wilfred Trotter would have approved of that.

It is beyond dispute that honours and awards have not escaped the contamination of politics, and that the ineptitude of their distribution is frequently ludicrous, whether exemplified by the sporadic distinction accorded to domestic workers in Whitehall or the routine biennial ration proffered with traditional pomp to more influential and possibly less deserving servants of the State and commerce. None the less, though downright baseness is not always excluded, and political mediocrity so consistently adorned, there remain good men in our own profession who have deserved the honour intended by the award they have received.

Indeed, unless honours and awards are to be entirely abolished (a step which to be consistent would need to be retrospective), or exclusively reserved for business men and politicians which would in the end amount to the same thing, it seems reasonable that doctors should treat this emotional business with clinical detachment, neither coveting on the one hand nor scorning on the other, but accepting such honours as come their way with the same equanimity with which they accept all other manifestations of praise or blame incidental to their calling.

Yours, etc.,

D. STAFFORD-CLARK.

Maudsley Hospital,
Denmark Hill, S.E.5.

The Anæsthetised Patient

SIR,—Following Mr. Rink's excellent Clinical Lecture, reported in your issue of the 5th July, might I beg a little space to emphasise one more point about the treatment of the anæsthetised patient. The patient still under an anæsthetic, after the operation has been completed, should be subjected to a minimum of movement; the need for remembering this varies directly with the age of the patient and the length of the operation.

Some time ago I took Blood Pressure readings of patients who had undergone Prostatectomy, Partial Cystectomy, etc. (*i.e.*, patients of the older age group), and constantly found a drop of up to twenty points during the time the patient was being rolled from side to side for cleaning purposes and for the placing of the many-tail bandage, after the actual operation had been concluded.

According, for some time past we have made it the custom at Orpington to return to the wards elderly patients who have had serious operations under prolonged anæsthesia "bloody but unbowed": they are cleaned up later by the ward staff when their general condition has improved and are thus spared the highly shocking postural changes so commonly inflicted on them at the time when they can stand these least.

It is interesting to note that lifting the lower half of a patient to enable the many-tail bandage to be slipped under him produces less fall in blood pressure than rolling him from side to side for the same purpose.

I am, etc.,

BRIAN D. JOHNSON.

County Hospital,
Orpington, Kent.

Sport

GOLF SOCIETY

On Monday, 30th June, we played St. Mary's Hospital in the University of London Golf League at Moor Park Golf Club. It was a most enjoyable fixture and after leading by 3 matches to 2 we won the last two matches on the eighteenth green to win by 5 matches to 2.

Arrangements have now been made whereby members of the Clubs' Union may play at Royal Blackheath Golf Club for 1s. 6d. a round. The course is about 5 minutes walk from Mottingham Station, and the journey from London Bridge takes about 30 minutes. All are cordially invited to avail themselves of this concession.

J. M. D. GRANT
Hon. Sec.

Hospital Information, etc.

NOTICES

DENTAL SOCIETY ANNUAL DANCE.

The Dance Secretaries have pleasure in announcing that the Annual Dance of Guy's Hospital Dental Society will be held at Grosvenor House, Park Lane, W.1, on Friday, 21st November, 1947. Dancing will be to the music of Sidney Lipton and his Orchestra, and a full buffet will be provided.

Applications for tickets, price One Guinea, may now be accepted.

I. A. NELSON,
A. H. R. ROWE,
Hon. Dance Secretaries.

GUY'S HOSPITAL MEDICAL SCHOOL.

Applications are invited for the post of Lecturer in Pharmacology. Candidates should be medically qualified. Commencing salary not less than £650 per annum with superannuation and family allowance. Forms of application may be obtained from the Dean, Guy's Hospital Medical School, S.E.1, to whom applications with the names of three referees should be forwarded not later than 15th August, 1947. The appointment will date from 1st October, 1947, and will be for two years in the first instance.

DEPARTMENT OF SURGERY.

On Tuesday, July 22nd, at 12 mid-day, there will be a demonstration in the series "Operative Procedures" in Theatre 2.

The Clinico-Pathological meeting due to be held on Saturday, July 26th, has been cancelled.

There will be no Departmental activities during the month of August.

GUY'S BIENNIAL DINNER.

Preliminary Notice.

The first post-war Biennial Dinner will be held at Grosvenor House Hotel on Friday, October 17th, 1947.

Invitations with further particulars will be circulated shortly to all qualified Guy's men—medical and dental.

SCHOLARSHIPS FOR NURSES.

The following Scholarships have been awarded to:—

Miss J. D. Jackson, Hospital Savings Association (Midwife Teachers).

Miss M. G. Stockdale, Hospital Savings Association (Sister Tutors).

Miss J. Rowbotham, Cowdray Scholarship.

NURSING STAFF.

There are vacancies for Staff Nurses in the Wards, Theatres, Nuffield House and other Departments of the Hospital. Senior post vacancies occur from time to time. Guy's trainees who are interested should apply to The Matron, Guy's Hospital, S.E.1.

PASS LIST

CONJOINT BOARD.

FIRST EXAMINATION.

June, 1947.

Anatomy and Physiology.

B. I. Copeland
A. C. de B. Eksteen
G. H. Kendall
D. Lennie
W. H. McKendrick
J. N. MacWilliam
G. O'Gorman
H. Schapira
H. N. St. John
P. A. Van der Merwe
R. I. J. Williams

Anatomy.

J. M. Stoner
G. R. Williams

Physiology.

R. D. Hernaman-Johnson.

Pharmacology and Materia Medica.

J. B. F. Boyle
P. Buri
M. P. Cardew
I. I. Eckstein
P. R. Harben
D. F. N. Harrison
J. L. Herbert
J. V. Kilby
A. G. McCallum
S. S. Maré
A. H. Mendoza
C. J. G. Menzies
A. M. Platt
D. F. Potter
H. H. Richards
P. R. M. Scales
R. D. Walsh

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

L.D.S.

FINAL EXAMINATION.

June, 1947.

Part I.—Surgery.

J. L. Attenborough
T. N. Chawla
M. W. Harber
R. L. Leader
D. W. Leatherbarrow
A. Levy
B. Lewin

Part II.—Dental Surgery.

T. N. Chawla
R. A. Dean
H. M. Hutchinson
A. Levy
B. Lewin
J. D. Morgan
P. B. Smith
M. J. L. Sykes
S. Torda
J. R. Wallis

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

Diploma in Anæsthetics.

J. E. Bulow
J. Gordon
R. M. de Gregory
J. H. G. Halliday
A. W. Hind
T. C. Thorne

ROYAL COLLEGE OF OBSTETRICIANS AND GYNÆCOLOGISTS.

J. R. Dickinson has been admitted to membership.

REGIONAL HOSPITAL BOARDS.

The Ministry of Health has now set up hospital boards for 14 regions of England and Wales. The following Guy's men have been appointed to the Regions indicated. All the appointments are honorary and unpaid.

East Anglican Region : R. B. Fawkes, D.S.O., M.C., M.R.C.P.

North-West Metropolitan Region : A. S. Gough, F.R.C.S.

North-East Metropolitan Region : H. A. Treble, B.M.; E. R. Boland, C.B.E., F.R.C.P.; A. T. Rogers, M.B.; W. Kelsey Fry, C.B.E., M.C., M.R.C.S., L.D.S.

Oxford Region : E. C. Bevers, F.R.C.S.

Manchester Region : Stanley Hodgson, M.D., J.P.

ROYAL SOCIETY OF MEDICINE.

Professor R. R. Macintosh has been awarded the Hickman Medal.

Dr. C. M. Wenyon, F.R.S., has been granted the diploma of Honorary Fellow.

The following Guy's men have been appointed Officers for the coming year :

Hon. Treasurer : L. R. Broster.

Member of Council : E. R. Boland.

GENERAL MEDICAL COUNCIL.

Sir Herbert Eason has been re-appointed to represent the University of London on the General Medical Council for a further period of 3 years, from November, 1947.

UNIVERSITY OF LONDON.

Dr. P. M. F. Bishop has been recognised as teacher of the University in Medicine.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

The following Guy's men were co-opted members of the Council for the ensuing year :

D. A. D. Marston. Mr. R. V. Bradlaw.

PAPERS BY GUY'S MEN

Allsopp, C. B. *Effects of Ultraviolet Radiation on 3, 4–Benzpyrene and other Polycyclic Aromatic Hydrocarbons.*

(1) Abscorption Spectra and Some Chemical Properties of the Water-Soluble Products. *Cancer Res.*, 1946, **6**, 14.

(2) The Role of Benzene in the Photoreactions in Solutions containing it. *Ibid.*, 22.

(3) Carcinogenic activity of Aqueous Extracts from Irradiated 3, 4–Benzpyrene. *Ibid.*, 24.

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Taylor, Florence E. Learning by seeing. 7. The Skeletal System. Diseases affecting Bone. *Nursing Times*, 1947, **43**, 417.

CHANGE OF ADDRESS

A. Bowen-Davies, M.B., F.R.C.S., 69, Harley Street, W.1. (Tel.: Welbeck 9721.); 34, Kensington Mans., Trebovir Road, S.W.5. (Tel.: FRO 2721.)

A. C. G. Freer, L.D.S., R.C.S., Box 334, Krugersdorp, Transvaal, S. Africa.

C. V. Kark, L.D.S., R.C.S., 29, Hatfield House, Cor. Eloff and President Streets, Johannesburg, S. Africa.

J. H. Mayer, M.B., B.S., F.R.C.S., 1, Connaught Way, Tunbridge Wells, Kent.

BIRTH

DARKE.—On June 19th, 1947, at Nuffield House Guy's Hospital, to Margaret (née Wild), wife of Christopher S. Darke, M.D., M.R.C.P.—a brother for Jonathan (Christopher Richard).

MARRIAGES

JEANES—JOHNSON.—On May 31st, 1947, at Bexley, C. W. L. Jeanes to Joyce Johnson, S.R.N.

ROSEVEARE—WEBB.—On July 5th, 1947, at St. Cyprian's Church, Clarence Gate, Regent's Park, N.W.1, Thomas Adams Roseveare to Barbara Jean Webb, S.R.N.

Eds. {D.H.F. H.A.R.

GUY'S HOSPITAL GAZETTE

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PASSIM

AMONGST any community of people there are always certain stock-in-trade subjects for discussion which never fail to arouse keen argument and, in many cases, a constant grumble. The most infamous of these topics, of which religion and politics are examples, is undoubtedly that of food, for it is something of which everyone is aware to a greater or lesser extent, depending on the quality of catering existent in that particular community.

"Hospital food is notoriously bad." This rather sweeping statement is very often made and not quite so often justified. In a teaching hospital where catering for the student is an additional and separate procedure from those that supply the patients and the nurses, there arises another field for criticism and it is generally the staff and students whose voices are raised the highest above the never-ceasing tumult of hungry tongues.

The present state of the country, with all the difficulties and deprivations that must, of necessity, follow a world war, makes the job of catering, be it for the housewife or the manager of a large restaurant, one that is not to be envied. The meagre rations and the extraordinary distribution of food generally is certain to produce much dissatisfaction which, although reasonable enough, is almost impossible to lessen, let alone dispel entirely. The pre-war courtesy that used to be extended to patrons by the waiting staffs is sadly lacking and tempers are apt to get frayed on both sides. The problems of acquiring (and maintaining) an adequate staff of helpers make those who supervise catering concerns very reluctant to intervene on behalf of the customer when disputes arise, and the shortage of such *crockerial* luxuries like saucers does much to detract from the attractiveness of the table.

The catering at Guy's for the students suffers from all these deficiencies and, in consequence, there is much disapproval expressed by those who attempt to feed in the college. Naturally, there are always persons in any institution who may be termed Resident Grumblers—they consider it their bounden duty to show disgust at almost any food with which they are provided, and due consideration must be made for this section of the population when the merits and demerits of any catering company are being assessed.

However, even after all allowances for the austerity of the age have been made, there is still much to warrant a great deal of this adverse criticism. To study in detail all the defects of each meal during the course of a day would be too laborious and too lengthy for such an article as this.

A student pays an annual subscription, part of which, he is told, is for the privilege of dining in the college. This privilege is, to say the least, an uncertain one for very often he is able to get better value for his money and better attention at one of the local eating-places outside the confines of the hospital, than he can in his own, albeit panelled, dining-hall. Furthermore there is

always a seemingly inexplicable shortage of supplies of certain commodities, like jam, butter and cheese, which, if not to be found in abundance elsewhere are, at any rate, to be obtained in fair quantities almost every day. There is also an amazing disproportion in the cost of certain items on the menu for, while some are reasonable (though very seldom cheaper than normal), others are fantastically high and should surely either be reduced in price or the quantity much increased.

Another queer aspect of dining-hall life that may be observed by the college-eater is the alarming number of supervisors that have appeared during recent months. Exactly who and what they supervise no one really knows, but there must be few situations more galling to the customer than that of being obliged to wait for some long period of time for service, while green-coated guardians of the kitchen stand immobile, prevented by sheer superiority of position from executing the menial task of carrying one cup of tea.

The intensely annoying custom which has been instituted, whereby entrance into the dining-hall is forbidden between a quarter to and a quarter past ten in the morning, is another point of vexation to the student who is desirous of obtaining some small cup of sustenance between lecture and morning round. The sole purpose of this ridiculous procedure would seem to be to provide a half hour's employment for one or other of the supervisors already mentioned who, daily, may be seen standing religiously true to her task as an egotistical Keeper of the Bolt.

The accommodation in the present college dining-room is very limited and, in being promised that very soon further catering facilities will be made available to the student, may we also look forward to a thorough investigation and readjustment of the present system so that Guy's men may be proud of their dining-hall rather than continuing to adopt their present attitude towards it which, at best, is one of dissatisfied tolerance of a place, whose only real merit is that it is near the wards.

The Use of Flaps

A Clinical Lecture delivered by NILS L. ECKHOFF, M.S., F.R.C.S.

GENTLEMEN,—Most laymen think that a plastic surgeon spends his time grafting skin from one part of the body to another, or even from one individual to another. Heterogenous grafting is of course impossible, for even though there may be an apparent early "take," antibodies are developed in the recipient, and the graft is thrown off. I have read of successful grafts between uniovular twins, but have had no personal experience of this.

The real test of a plastic surgeon is his skill in the use of flaps, particularly local flaps. If the defect is more than skin deep, free grafting has little value, and flaps are essential.

Flaps may be classified thus :—

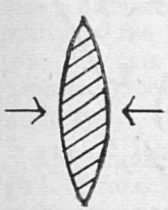
Local flaps.
Direct flaps—from one part to another.
Flaps from a distance.
Tube pedicles.

One frequently hears the term "pedicled flap." This is redundant, for every flap must have a pedicle, or it would die. The width of the pedicle is extremely important, and many flaps are doomed to failure from the start by having an insufficient pedicle. The width of the pedicle should in most areas be equivalent to the length of the flap. A notable exception is the forehead, where the vascularity is such that the flap may be designed with a length greatly exceeding the width.

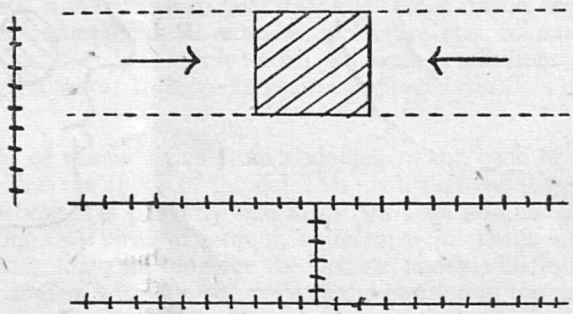
Local flaps. These are subdivided into

1. Sliding flaps.
2. Advancement flaps.
3. Rotation flaps.
4. Transposition flaps.

Sliding flaps are used every day by all surgeons, whenever an ellipse of skin is removed, as in the removal of a simple skin tumour. The flaps are undermined, and the edges brought together. Many operations fail by insufficient undermining. Remember also that there is little skin to spare on some parts of the body, *e.g.*, the limbs, and it may be impossible to bring the edges together without undue tension, even after relatively small excisions. On the face quite big excisions can be repaired, the more so the older the patient, but careful study is necessary to avoid distorting the eyelids, nose or mouth. Remember also to study the skin lines (Langer's lines) for incisions parallel to those lines produce an almost invisible scar, whereas those at right angles to those lines produce wide keloidal scars. The common longitudinal incision in front of the wrist, for removal of ganglion is quite unnecessary, and many young girls are sadly marked for life.



Sliding Flaps



Advancement Flaps

Some months back there was some stir in the medical (and lay) press following an article by Margaret Tod intended to show that the removal of pigmented tumours (melanomata) was unwise, lest malignant properties be stimulated. I agree that wholesale removal of melanomata is unnecessary, and that imperfect removal or destruction with heat or cold is dangerous—but feel that melanomata in a position subjected to irritation are better removed cleanly—and the skin brought together—if possible—by sliding flaps.

Advancement flaps.

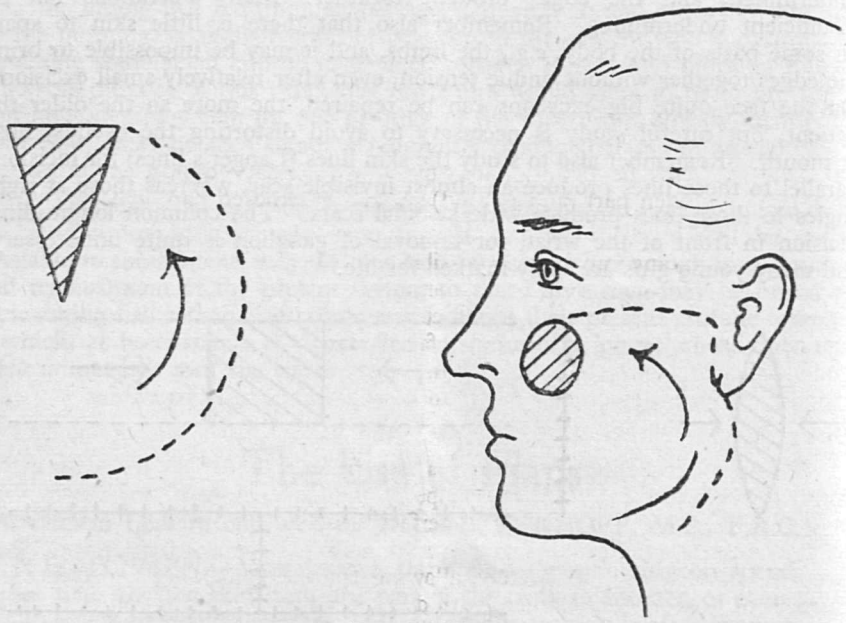
For diagrammatic purposes it is best to visualise a defect of quadrangular shape. Parallel incisions are made continuous with two of the sides of the defect, marking out an elongated quadrangle. The skin and subcutaneous

tissue are dissected up. It will then be found that the elasticity of the tissues will allow the flaps to be "advanced" to fill the defect. Note that the flap I have just described is longer than it is broad, and must therefore be designed with great caution. If local conditions permit the design of a flap from each side of the defect this danger is minimised. On some situations the flap may with profit be wedge shaped. This improves its vitality, and also brings more skin into the defect if this is needed to correct a deficiency, *e.g.*, ectropion.

A simple advancement is the V-Y procedure. An incision in the shape of a V is sutured as a Y. A double V-Y procedure is sometimes used for small defects at the back of the heel.

Rotation flaps.

These are much favoured by certain continental surgeons. For diagrammatic purposes imagine an isosceles triangle. If a half or threequarter circle be drawn using one of the long sides as a radius, it is easy to understand



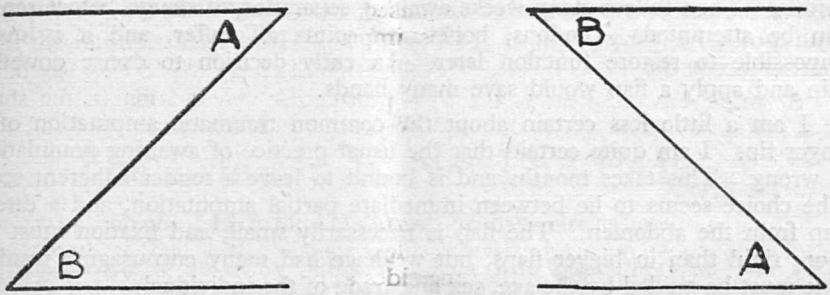
Rotation Flaps

that if the whole flap is lifted, it can be rotated to fill the defect. A simple example in practice is the removal of a piece of skin from the zygomatic region. The flap is marked out by a line running to the front of the ear—skirting the auricle, and passing if necessary below the ear into the neck. If carefully lifted—rotated—and sutured, a fine scar should result, which is almost invisible.

Transposition flaps.

As the name implies, the flap is lifted and transposed over a gap. It is particularly useful in and around the lips, to correct an upward or downward drag of the angle of the mouth, by transposing a flap from the upper to the lower lip, or vice versa. Another useful variant is the Z plasty, to overcome a web contracture. The long limb of the Z is along the web. When the flaps

are lifted, the two triangles are transposed, and sutured as a Z, thus breaking the lines of the web. Quite complicated mathematics have been applied to the study of Z plasty.



Transposition Flaps

The forehead flap, so useful in restoring defects of the nose or cheek, is really a variety of transposition flap—although the operation can rarely be completed in one stage.

In all these local flap operations minor skin triangles may have to be excised to make the flaps lie better. Sometimes a secondary defect is deliberately created in a hidden part (and grafted) so that an exposed part may be covered with good skin.

In planning any repair, the possibility of local flaps must be thoroughly explored before considering other methods, because however excellent a flap from a distance, or a graft, it is difficult to guarantee the colour match or the quality of the skin. For example, facial skin has a texture and coloration quite different from abdominal skin. Only when all local possibilities are exhausted, does the surgeon resort to more complicated procedures.

Direct flaps.

The simplest example of this is a flap from abdomen to the back of the hand, or forearm. Provided the shape of the defect is such that the flap can be designed with a wide base it is perfectly safe to lift the flap, and attach it to the defect at one sitting. A piece of jaconet, or transparent plastic sheet is cut to fit the defect accurately, allowing for the pedicle, and placed in the correct position of the abdomen, with due reference to the position of the main arteries. It is marked out with ink, lifted, and sewn into position. The raw surface of the abdomen may be grafted at the same time or later.

This direct abdominal flap is much better than the tunnel operation described in some of the books, for the latter is very difficult to design accurately, and discharge from the inevitable raw area is messy and leads to maceration of the buried area. With the flap described it is possible to pronate and supinate the forearm, which not only gives the patient welcome relief, but also allows for complete and proper cleansing, without which quick and good healing is impaired.

It is this type of direct abdominal flap that I want to commend to those of you who will be doing emergency surgery. Not infrequently patients are brought in with extensive skin and subcutaneous tissue loss of the hand or arm. An immediate direct flap operation may save untold delay, and

further destruction of tendons and bones. Extensive stripping injuries without loss are more difficult. We have all endeavoured to save a piece of skin when our better judgment has told us it was doomed. Even if there is an adequate base or pedicle, there is often thrombosis in vessels which makes necrosis certain. Then follow many weeks awaiting separation of slough before repair can be attempted. Tendons, bones and joints all suffer, and it is quite impossible to restore function later. An early decision to excise doubtful skin and apply a flap would save many hands.

I am a little less certain about the common traumatic amputation of a finger tip. I am quite certain that the usual practice of awaiting granulation is wrong. This takes months and is bound to leave a tender adherent scar. The choice seems to lie between immediate partial amputation, and a direct flap from the abdomen. The flap is necessarily small, and fixation must be more rigid than in bigger flaps, but we have had many encouraging results. One must be guided by the age, sex and trade of the individual.

A cross-leg flap is another example of a direct flap. Here a flap of skin is raised from one leg in the calf region and attached to the defect in the other leg. It can replace scar tissue on the heal or foot, where a free graft would be of little value. If the shape of the proposed flap is unhappy it is common to " delay " its attachment. This is done by marking it out very carefully, after measurement with a pattern. The side edges are incised, but not the tip. The flap is lifted, and immediately replaced in its bed, and sutured carefully. This encourages the blood vessels to dispose themselves along the length of the flap. Some ten to fourteen days later the whole flap is lifted and attached to the defect. It is useful to fix the legs in plaster of paris.

Flaps from a distance.

Occasionally a predesigned flap on the abdomen is attached to the wrist and later transported to the face. By this means it is possible to cover as much as half the face. But the transport of large pieces of skin by this means is fraught with danger and it is more usual to make use of the tube-pedicle.

Tube pedicles.

By forming a piece of skin into a tube it is possible to close all raw surfaces, and to encourage the blood supply to develop in a longtitudinal direction. The tube is usually constructed from a piece of skin and subcutaneous tissue about 6 in. $\times$ 3 in. It can be lengthened later if necessary. The selected piece is measured and marked out, usually running from the flank towards the pubis, the long sides of the quadrangle are incised so as to include the requisite amount of fat. The intervening tissue is elevated, and rolled to form a tube, skin surface outside, and sutured. The raw surface is usually closed by undermining and approximation, though a graft may be required.

After three weeks one end of the tube can be divided and attached to the wrist. In another three weeks the other end can be divided, and attached to the defect. Another three weeks, and the hand can be liberated. It is possible at this stage to open out the tube and apply it to the full defect, but caution often dictates that only the free end shall be implanted at this date, and the final opening out delayed still longer. It is indescribably tragic to lose a portion of a tube pedicle at this stage. A good deal of skill and care is required to bring such a plan through without hazard, which makes another reason for preferring simpler procedures where possible.

I should like to emphasise one more point. If the defect includes an opening into one of the cavities of the face—mouth, nose, antrum or sinuses—no flap or pedicle can be applied without providing a lining. This is obtained by flaps turned in from the edges of the defect (thereby increasing its size) or occasionally by grafting the deep surface of the flap, before transposition.

In the multiple stage operations three weeks is the usual interval between operations.

The Late Mr. F. Newland-Pedley

BY B. LEES READ (CLERK TO THE GOVERNORS).

THERE must be many old Guy's men who remember the late Mr. Newland-Pedley who, together with the late Sir Cooper Perry, founded the Dental School at Guy's Hospital in 1889.

From the founding of the School to the present day is a long step, and the School must have been very dear to Mr. Newland-Pedley, as, when he died at Acquaseria, near Como, Italy, on the 4th May, 1944, he bequeathed to the Governors of Guy's Hospital the residue of his estate, approximately £60,000. Under the terms of the bequest, the Governors are to hold the whole of the residuary estate in trust to commemorate his connection with the Dental School, and the income of the estate is to be applied to the endowment of existing prizes and scholarships, or to the establishment of others in connection with the Dental School.

Details of the bequest were communicated to the Hospital, and it appeared that the first charge on the estate was the provision of annuities, amounting to £900 per annum, to five Italians. Owing to a mistake in law, the Executor named in the Will could not act and renounced probate, and the Court of Governors of Guy's Hospital nominated me to take out Letters of Administration with Will annexed in order to deal with the estate on behalf of the Hospital and School.

As Mr. Newland-Pedley was domiciled and died in enemy territory during the war, his property was subject to the rules governing the properties of enemies and aliens, and was controlled by the Custodian of Enemy Property. It is not intended, however, here to give a detailed account of the legal difficulties involved in the administration of the estate, but it will be obvious that one of the first actions necessary was to make sure that the Italians entitled to annuities were, in fact, alive, and to endeavour also to find out if, in addition to the English estate, there was any property in Italy.

I therefore made arrangements to go to Como, and, in the course of carrying out the necessary work, was given a great deal of information about the last years of the life of this distinguished Guy's man.

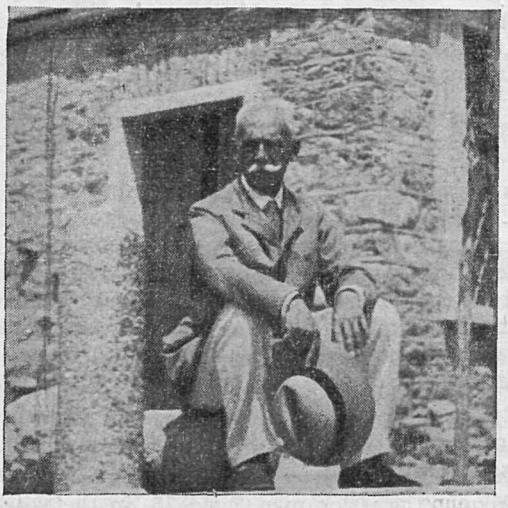
He arrived in the village of Acquaseria a sick man, aged 75, in the year 1930, and asked for accommodation at a small hotel. Immediately he had to go to bed and was nursed through a serious illness by the owners of the hotel. He made, however, a very good recovery and, after some time, stated that he had not enjoyed such good health for years and intended to make this place his home for the rest of his life. Subsequently, he persuaded the owners of the hotel to sell this and to purchase a villa where he was the sole

guest and, in return, promised to provide for their future which, in fact, he did by the annuities granted in his Will.

He became in every sense of the word the Patron of the village of Acquaseria, and I heard many interesting stories of his interest in the people and the good that he did.

One exceptional act was to build a Church. It was built not out of any religious inclination, but because of the poverty that had descended on the village by reason of the application of sanctions against Italy during the Abyssinian War. This had closed the only industry in the village and reduced the population to starvation level. There was no unemployment pay or public assistance comparable with that in force in England and Mr. Newland-Pedley was very concerned about the well-being of these people who had become his friends.

He had, however, the common aversion of the English to paying out money without seeing some return and, as he was anxious to help the village through its difficulties, he made a suggestion to the Parish Priest that he should pay so much per week to every able-bodied man on condition that he did a full week's work in the quarrying and hauling of stone and in the erection of the village Church, which at this date and for many years previously had really existed in name only consisting of the foundations, and a crypt in which were held religious services. Needless to say, the Parish Priest received the suggestion with enthusiasm and as Mr. Newland-Pedley left him to see what work he got in exchange for the sums disbursed, I was assured that the villagers had to put in both a full and a hard week's work to claim the monetary payment !



Mr. Newland-Pedley in front of the Church during the course of its erection.

The result was a very picturesque stone Church, erected in the village at a cost of approximately £1,500, and a large marble plaque on one of its walls commemorates the late Mr. Newland-Pedley's generosity.

Many other instances of his desire to help the population of the village, but, at the same time, to do it his own way, were reported to me.

On one occasion he purchased the entire stock of the village sweet-shop, had this made up into small packets and distributed them amongst the children attending the school. The religious sisters, who were the teachers in the school, went to see Mr. Newland-Pedley, and remonstrated gently with him that there were many things that were necessary and which would benefit the children infinitely more than sweets, for example, new blackboards in the school ; and they suggested to him that if he was contemplating making

further gifts they should have an opportunity of suggesting the form these should take. I understand that Mr. Newland-Pedley was later heard to remark that he knew far better than any teachers or others what was good for children and what they liked.

On another occasion, during a severe winter, he purchased pink woollen jerseys and skirts for all the girls under seven attending the school, and navy blue jerseys and shorts for all the boys, and strong boots for all these children; and, although he always emphatically refused to entertain suggestions put forward by different people connected with the village, it was noticed that nevertheless, these suggestions sometimes bore fruit at a later date.

There is no question, however, that the least pressure brought to bear upon Mr. Newland-Pedley would inevitably bring an unexpected reaction, and this soon came to be appreciated. I am quite prepared to believe that some suggestions were made in the hope that, in seeking the opposite, Mr. Newland-Pedley would, in fact, do what was desired. This could hardly have been the result when, on being asked to help in the provision of certain facilities for the education of elder children, he retorted with the purchase of a hoop and stick for every child in the school!

Almost up to the time of his death he retained his independence and mental alertness, as well as a determination to carry out anything to which he set his hand. A story was told of how, on one occasion, when with some friends in the village he had been to see someone who was ill, he was confronted with a jump of about three to four feet down into a sunken road. As he was then about eighty-six, one of the party went to lend assistance. This was abruptly refused, with the comment that he would make the jump himself even if it killed him!

One thing he always refused to do, and, during the whole of his connection with the village, adhered to his decision, namely, in no way would he attempt to carry on his profession.

There are many other instances of his interest in the village and its inhabitants, and nearly all of these showed his interest in the young. Just as he had founded a school for dentistry at Guy's, so he was interested in the welfare of the young in this small mountain village. His name is almost a legend there for his many acts of generosity and forethought. Although it is, in a sense, an isolated area and, particularly during the time of the Abyssinian War and in the first three or four years of this last war, there were many bad characters either living in or roaming the neighbourhood, it is said that, although English, he could have walked alone and would never have been harmed anywhere in the district for miles around.

The payment of five substantial annuities to Italians may, at first sight, appear rather strange, but, as regards three of these, they were undoubtedly earned by the three elderly people who for almost fourteen years devoted themselves to his care. With regard to the other two, these, again, indicate Mr. Newland-Pedley's interest in young people. Under Italian law, I believe it was the position that an afflicted relative had to be maintained by the family; and a sister of his housekeeper had two children, both girls, one of whom has only a childish mentality and is deaf and dumb. Mr. Newland-Pedley was concerned at the thought that in due time responsibility for this child would fall on her sister, the only other member of the family, hence one of these annuities was given with the object of reducing that burden. The

second of the annuities given for reasons other than service was to another neice of his housekeeper, and was given to provide for her future purely because of the affection which Mr. Newland-Pedley had developed for this child during the period of almost twelve years he had watched her growth.

I am exceedingly sorry that the war between Italy and this country appears likely to have the effect of depriving these people of much, if not all, of the benefit which Mr. Newland-Pedley wished to confer. Even when I had to break the news to them that the annuities are at present payable to the Custodian of Enemy Property in this country, and that they would have to take their chance of recovering them from the Italian Government, their only comment was " I suppose this is another present from Mussolini."

Mr. Newland-Pedley would never agree with the idea that Italy might be at war with this country and steadily refused to make any financial arrangements which would have helped him in that event. The result of this was that after the outbreak of war he had only the very small allowance permitted by the Italian Government, and he had to be maintained very largely by the people he had befriended and who also had to meet the expenses of his funeral. On more than one occasion during the last years of his life he said " I am very tired of being poor," and for some time after the outbreak of war he could not be persuaded that it was impossible for him to obtain money from England so that he could carry on as usual.

Never at any time during the war was Mr. Newland-Pedley interfered with by either the Italians or the Germans ; no restrictions were imposed, and he was left free to live as he had done in the past. Before his death, however, he had expressed a wish to be buried in a particular place, but, when enquiries were made with this end in view, the German Commandant for the area refused permission for the removal of the body, as the proposed place of burial was in one commune and the place of death in another ; he had, therefore, to be buried in the cemetery nearest the villa in which he had lived.

Guy's men have been responsible for many things from time to time, but it must surely be unique for one to found a school in his own country and to build a church in the country of his adoption.

Reviews

The Conquest of Disease. By GEORGE BANKOFF, M.D., F.R.C.S. MacDonald. *Price* 6*s.*

THIS book, which is the first of the " Conquest " Series, deals with the story of Penicillin. George Bankoff, an author of some repute, can make a story flow, where another surgeon would make history heavy going. It is a book—as are all in this series—designed for the layman, but this does not detract from its interest. The author does not make the mistake of skipping lightly over even the important but difficult aspects of bacteriology, but probes quite deeply into it.

The history of the discovery of Penicillin is very good, but perhaps the book wanders too far from the plains of reality when envisaging the future of Penicillin—even in cigarettes. But who can tell? C.S.G.M.

The Eternal Child. By EVELYN WHITE. Chapman & Hall, Ltd. *Price* 6*s.*

THIS somewhat breathless little handbook gives one something of the feeling that one is rushing through an interesting country in an express train.

The occasional attractive flashes of humour and glimpses of insight leave one regretting that an almoner of such long standing could not give more from her own ripe experience and original impressions, and less of the text-book type of information which must of necessity be somewhat superficial in a work of this kind. E. A.

Sport

GOLF SOCIETY

A Spoon competition was held at Sidcup Golf Club on Wednesday, May 7th. Owing to the exceptionally bad weather which caused postponement of our fixtures last term, this was our first meeting since the post-war revival of the Society and, for a change, conditions were ideal.

There was a good entry and considering that few of us had seen the course before, scores were quite respectable. We congratulate D. F. Cottier on winning the spoon with the very good score of 33 points.

Leading scores were :—

D. F. Cottier (10)	33 pts.
J. K. Anderson (10)	28 pts.
N. E. Price (12)	28 pts.
J. M. D. Grant (3)	25 pts.
C. J. G. Menzies (16)	23 pts.
J. D. Crowlesmith (16)	23 pts.
W. Vans Agnew (12)	20 pts.
J. L. Harrington (16)	19 pts.

Our first match of the year was played against St. Thomas's Hospital at Sidcup, on Wednesday, May 14th, and resulted in a win for us by 4 matches to 2 with two halved.

Results of matches were :—

GUY'S HOSPITAL.

J. M. D. Grant	0
D. F. Cottier	0
J. K. Anderson (4 and 2)	1
D. M. Griffith (2 up)	1
N. E. Price (2 up)	1
J. D. C. Crowlesmith (1 up)	1
C. Menzies (All Square)	½
J. L. Harrington (All Square)	½
	5

ST. THOMAS'S HOSPITAL.

F. B. Briggs (5 and 3)	1
D. C. Stevenson (2 and 1)	1
P. S. Moore	0
G. Carnegie	0
A. F. Barnett	0
A. C. Barnett	0
—. Fitzgerald	½
—. Fitzgerald	½
	3

A University of London Golf Trial Match will be played at Sundridge Park Golf Club on Wednesday, May 28th.

The Inter-Hospitals Golf Cup Competition is being revived and will be held at Sundridge Park Golf Club on Wednesday, June 11th.

Once again we would like to add that a full list of fixtures has been arranged for 1947. The first competition was well supported and we look forward to an even larger entry in the future now that the ice has been broken. All who are interested in Golf are welcomed. Notices of forthcoming events are posted from time to time on the notice board in the Colonade, and full details may be had from the Hon. Secretary.

J. M. D. GRANT,
(Hon. Sec.).

ASSOCIATION FOOTBALL CLUB

2ND ROUND INTER-HOSPITALS CUP COMPETITION.

(Played against U.C.H., on Saturday, March 22nd, at H.O.P.)

Result : Won 4—1.

After many rearrangements caused by the appearance of an "Arctic" Britain, this match was eventually played, on a pitch that was not completely ideal as the snow had left it looking like a quagmire.

Unfortunately, U.C.H. found themselves one man short when the team had assembled, but despite their "ten-men" team, our opponents, straight from the kick-off, caught the defence napping, and scored the quickest goal on record. Guy's were slow to recover from this set-back, and it was not until just before the interval that Leckie, our centre-forward, managed to equalise with his usual well-placed shot.

The interval was a badly-needed break in the game for it gave Guy's the opportunity to realise, that in order to hold the Cup yet another year, they must force some goals in the second half.

Soon after the restart, Ian Munro scored a very good goal from an acute angle on the right wing. Half-way through the second half a heavy fall of snow and sleet began, and in these miserable conditions Leckie added two more goals to bring the final score to 4—1.

GUY'S *v.* SOUTHWARK PARK FOOTBALL CLUB.

(A Charity Football Match in aid of the Hospital Funds, played on April 22nd at Barrow Blackman Sports Ground, Downham.)

Result : Lost 1—3.

This match was staged through the hard work and generosity of Mr. Betts and a large band of voluntary helpers. To add to the attraction of the match

itself, they had asked Miss Lind Joyce—of ITMA fame—to kick off. The Club would like to express its thanks to Miss Joyce for giving up some of her valuable time to help the Hospital.

The match was played in a high wind which swept from one end of the pitch to the other. Riches, our Captain, winning the toss, elected to play the first-half with the wind. Right from the start the whole team realised that our opponents were wise to all the tricks of the trade.

The only score in the first-half came after twenty-five minutes play, when Sturdy, playing centre forward, placed a perfect half-volley safely into the net. Despite repeated attacks on the opposing goal the score at half-time stood at 1—0 in our favour. Our forwards found that the wind was taking passes far in front of them.

In the second half it would appear that Southwark Park made better use of the wind and moved every man except a full-back into our half, and in this way scored three goals. One of these goals was scored from a well-placed corner kick, which the inside-left successfully glided into the net.

We welcomed the opportunity of meeting near-neighbours of the Hospital at Soccer, and like Mr. Betts, look forward to an annual fixture with them.

SQUASH RACQUETS CLUB

The result of the Finals of the squash racquets knockout competition, played on April 24th, was as follows :—

L. Jacobs beat A. W. R. Williamson.
(9—4, 9—6, 9—2)

At a meeting of the Squash Racquets Club, the following officers were elected for the season 1947–48 :—

To be Captain : C. J. A. Menzies.
To be Secretary : H. Aikett.

The retiring captain, Mr. P. S. Carton Kelly congratulated the team on their recent successful season and thanked them for the enthusiasm which they had showed.

C.J.G.M.

House Appointments

MAY 1ST—JULY 31ST, 1947.

Revised List.

GUY'S.

ASSISTANT HOUSE SURGEONS.

To Mr. Slesinger and Mr. Brock	J. G. Stebbing	*New Appointments.*
To Sir Heneage Ogilvie and Mr. Atkins	J. M. Holmes	
To Mr. Massie and Mr. Wass	T. E. Oppé	
To Mr. Eckhoff and Mr. Blackburn	J. M. Hall	

OUT-PATIENT OFFICERS.

L. J. Evered	(Resident)	*New Appointments.*
J. G. Hamilton	(Resident)	
H. Goldschmidt	(Non-Resident)	
M. B. Conran	(Non-Resident)	

HOUSE PHYSICIANS.

To Sir John Conybeare and Dr. Hardwick	R. C. Hallam*	*Reappointments.*
	R. L. Ray*	
To Dr. Campbell and Dr. Hampson	J. Crossley	*Reappointments.*
	M. G. D. Davys	
To Dr. Douthwaite and Dr. Mann	H. B. F. Ordish*	*Reappointments.*
	D. H. Broughton*	
To Dr. Boland and Dr. Baker	B. Rowlatt*	*Reappointment.*
	T. W. Renton*	*New Appointment.*

HOUSE SURGEONS.

To Mr. Slesinger and Mr. Brock	I. D. Henderson*	*New Appointment.*
To Sir Heneage Ogilvie and Mr. Atkins	R. Rowlandson*	*Reappointment.*
To Mr. Massie and Mr. Wass	M. M. Figgis*	*Reappointment.*
To Mr. Eckhoff and Mr. Blackburn	R. N. Ticehurst*	*New Appointment.*

*Ex-Service Medical Officer.

RESIDENT OBSTETRICIANS.

G. M. Evans* —May 1st–July 31st. *New Appointment.*
G. J. Amiel* —May 1st–June 30th. *Reappointment.*
D. H. Crook* —June 1st–Aug. 31st. *Reappointment.*
M. D. Keats* —July 1st–Sept. 30th. *New Appointment.*

CHILDREN'S HOUSE PHYSICIANS.

G. W. Downes* (Resident) *Reappointment.*
W. Humphreys* (Non-Resident) *Reappointment.*

THROAT AND EAR HOUSE SURGEON.

J. D. Trethowan* (Non-Resident) *New Appointment.*

OPHTHALMIC HOUSE SURGEON.

D. J. Tibbs* (Non-Resident) *New Appointment.*

FRACTURE HOUSE SURGEON.

E. W. Crews* (Non-Resident) *Reappointment.*

BACK SURGERY HOUSE SURGEON.

G. J. L. Davies* (Non-Resident) *Reappointment.*

NEUROLOGICAL HOUSE PHYSICIAN.

G. M. Coupland* (Resident) *Reappointment.*

DERMATOLOGICAL HOUSE PHYSICIAN.

M. A. Shellim* (Non-Resident) *New Appointment.*

ORPINGTON.

HOUSE SURGEON. I. Yentis *New Appointment.*
A. P. Baker *Reappointment.*
THROAT AND EAR HOUSE SURGEON. J. B. Eades *New Appointment.*
ORTHOPÆDIC HOUSE SURGEON. D. O. Davies *New Appointment.*

JOYCE GREEN.

HOUSE SURGEON. W. Sewell* *New Appointment.*

PEMBURY.

HOUSE SURGEONS. D. G. A. Westbury, P. J. Dwyer } *New Appointments.*

*Ex-Service Medical Officer.

Hospital Information, etc.

NOTICES

GUY'S HOSPITAL MEDICAL SCHOOL.

Applications are invited for the appointment of Assistant to the Director of the Department of Medicine. The appointment is for two years in the first instance, to commence as soon as possible. Applicants should hold the M.D. or M.R.C.P. Salary £750–£1,000 per annum, with superannuation and family allowance. Copies of Standing Orders for the appointment are obtainable from the Dean to whom ten copies of application, with the names of three referees, should be forwarded not later than 14th June, 1947.

Applications are invited for the appointment of Assistant to the Director of the Department of Surgery. The appointment is for two years in the first instance, as from 1st September, 1947. Applicants should hold the M.S. or F.R.C.S. Salary £750–£1,000 per annum, with superannuation and family allowance. Copies of Standing Orders for the appointment are obtainable from the Dean to whom ten copies of application, with the names of three referees, should be forwarded not later the 14th June, 1947.

Applications are invited for the post of Chief Clinical Assistant and Registrar in the Ophthalmological Department. Duties to commence immediately. Honorarium to be at the rate of £105 per annum, for attendance on one session per week. Forms of application are obtainable from the Dean, Guy's Hospital Medical School, to whom applications, with the names of three referees, should be forwarded at once.

JUNIOR STAFF APPOINTMENTS.

Applications are invited for the Junior Staff appointments listed below for the session 1947–48. Forms of application are obtainable from the Medical School Office and should be lodged with the Dean not later than 14th June, 1947.

Tutor in charge of the Preliminary Clinical Period Class. (1)
Medical Registrar. (4)
Surgical Registrar. (2)
Clinical Assistant in the Department of Diagnostic Radiology. (2)
Clinical Assistant and Registrar in the Ophthalmological Department. (2)
Chief Clinical Assistant and Registrar in the Dept. of Psychological Medicine. (1)
Chief Clinical Assistant and Registrar to the E.N.T. Department. (1)
Chief Clinical Assistant and Registrar to the Dept. for Nervous Diseases. (1)
Department of Morbid Anatomy and Histology
Assistant Lecturer (Griffiths) (1)
Gull Student (1)
Demonstrators (2)
Department of Clinical Pathology
Assistant to Director (1)

Assistant Clinical Pathologists (3)
Department of Clinical Pathology
Assistant Lecturer (1)
Demonstrators (2)
Chemistry Department
Assistant Lecturer. (1)
Demonstrators (2)
Physics Department
Assistant Lecturer. (2)
Demonstrator. (1)
Biology Department
Assistant Lecturer. (1)
Demonstrators. (2)
Anatomy Department
Assistant Lecturer. (2)
Demonstrators (3)
Physiology Department
Assistant Lecturer (and Anderson Demonstrator of Clinical Chemistry) (1)
Pharmacology
Assistant Lecturer. (1)

GUY'S HOSPITAL.

Applications are invited for the following posts. Duties to commence on October 1st, 1947. Applications should be lodged in the Superintendent's Office not later than June 14th :—

Assistant Director (Female), V.D. Dept. (1)
Medical Officers (Male), V.D. Dept. (2)
Medical Officers (Female), V.D. Dept. (2)
Chief Clinical Assistant, Radiotherapy Dept. (1)
Radium Registrar (1)
Dental Officer to Salomon's Centre (1)
Dental Anæsthetist to Salomon's Centre (1)
Orthodontic Assistants (3)

T. B. JOHNSTON,
Superintendent.

DEPARTMENT OF SURGERY.

On Saturday, May 31st, at 10.30 a.m., there will be a Clinico-Pathological Meeting in the Anatomy Theatre.

On Tuesday, June 3rd, at mid-day, there will be a demonstration in the series "Operative Procedures" in Theatre No. 2.

H. J. B. ATKINS,
Director to the Department of Surgery.

STUDENTS' UNION.

Prof. T. B. Johnston will be giving his Presidential address to the Students' Union on Thursday, May 29th, in the Physiology Theatre at 4.30 p.m.

J. PALMER,
Hon. Sec.

PASS LIST

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

F.R.C.S.

PRIMARY EXAMINATION.

H. L. Brunow
P. B. Counsell
A. G. Ellerker
D. N. Fuller
H. P. Guerrier
P. G. Large
A. E. Loden

AMENDMENT.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

M.R.C.P.

April, 1947.

P. R. A. May
T. M. L. Price
J. S. Stead

UNIVERSITY OF CAMBRIDGE.

The degrees of Bachelor of Medicine and Surgery have been conferred on J. G. Mathewson.

ROYAL COLLEGE OF OBSTETRICIANS AND GYNÆCOLOGISTS.

DIPLOMA IN OBSTETRICS.

March, 1947.

J. A. Bowen-Jones
St. J. M. A. Tolhurst

PAPERS BY GUY'S MEN

Andy, J. R. Scrub Typhus as a Study in Ecology. *Nature*, 1947, **159**, 295.

Blockley, C. H. Root absorption following orthodontic treatment. *Brit. Dent. J.*, 1947, **82**, 168.

Cathie, I. A. B. The treatment of Erythroblastosis Fœtalis. *Arch. Dis. Childh.*, 1947, **21**, 229.

Cutler, Robert. Let us look back. *Dental Rec.*, 1947, **67**, 87.

Hardwick, C. Hepatitis. *Clin. J.*, 1947, **76**, 88.

Moiser, Bernard. Leprosy: A new outlook. *E. African Med. J.*, 1946, **23**, 295.

Ogilvie, Sir Heneage. Surgical handicraft. *Lancet*, 1947, i, 543.

Taylor, Florence E. Learning by seeing: 5. The female reproductory system. *Nursing Times*, 1947, **40**, 256.

CHANGE OF ADDRESS

Charles Baker, *O.B.E.*, M.D., The Wardens' House, Guy's Hospital, S.E.1. (Tel.: Hop 0353.)

P. D. Bryant, S/Ldr. R.A.F., 190691, R.A.F. Hospital, Changi, Singapore.

Barbara Wickham, Colonial Nursing Service, Kasama, N. Rhodesia.

BIRTHS

BAKER.—On May 7th, 1947, at Nuffield House, Guy's Hospital, to Mrs. David Baker—a son (Keith Warren).

COX.—On May 6th, 1947, at Guy's Hospital, to Betty (née Padbury), wife of A. G. C. Cox, M.R.C.P.—a son (Christopher John).

EDMONDS.—On April 27th, 1947, to Mary (née Winnett), wife of F. J. H. Edmonds, T.D., L.D.S., R.C.S.Eng., of 2, Cobham Street, Gravesend—a daughter (Hilary).

KENNEDY.—On May 15th, 1947, at Carlisle, to Minnie, wife of G. C. Kennedy—a second son (Michael Gordon).

REINHOLD.—On April 28th, at Guy's Hospital, to Jeune (née Dalton), wife of John D. L. Reinhold, B.M., B.Ch., of 18, Holly Lodge Gardens, Highgate, N.6—a daughter.

SMITH.—On April 21st, 1947, at St. Leonards-on-Sea, to Renée (née Kirk), wife of Capt. W. H. Smith, R.A.M.C.—a son (William Homer).

VORSTER.—On March 28th, 1947, at Krugersdorp Hospital, Transvaal, S. Africa, to Brenda (nee Melville), wife of Steve Vorster, L.D.S., R.C.S., daughter (Fiona Hester), sister for Diane and Paul.

MARRIAGES

ATTALE—KEARNEY.—On 5th April, 1947, at the Church of SS. Michael and John, Dublin, Jeffery E. Attale, Surg. Lieut. (D), R.N.V.R., to Margaret Josephine (Margot) Kearney.

AUDY—MURRAY.—On March 26th, 1947, quietly in South London, Lieut.-Colonel J. R. Audy, R.A.M.C., to Catherine Murray, of Tunbridge Wells.

BURT—WHITE.—On May 10th, 1947, at Felixstowe Parish Church, Lt. J. R. Burt, R.A.D.C., to Miriam Mary White, only daughter of the late Cyril White and of Mrs. R. M. White of Lewisham, London, S.E.13.

MACLEOD—LEWIS.—On April 24th, 1947, at Holy Trinity Church, Wallington, Ian S. MacLeod, M.B., B.S., M.R.C.S., L.R.C.P., to Joan Elizabeth Lewis.

SCOTT—PASCALL.—On April 26th, 1947, at S. Croydon, Leslie Gordon Scott, M.B., B.S., to Esmé Ruth Pascall.

Eds. {D.H.F. H.A.R.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LXI. No. 1536 *7th June* 1947 *Ninepence*

PASSIM

GUY'S, as you may imagine, is very sticky this weather. Enviously we think of those of our readers (we hope there are some) who are out of town, spending their evenings, at least, bathing in cool rivers or drinking iced lager under the shade of lime trees, listening to the pong of tennis ball and racquet and inhaling the sweet scent of summer flowers. Oh dear, the oppressive heat, the smell of hops, dust in the eyes and nose, and the everlasting rumble of traffic! It seems so little time ago that we were frozen up, with no running water in the College, even the sterilisers in the wards frozen, and everywhere outside alternately the squelch or crunch of snow, that we must not grumble, but forgive a little exclamation, and rather more than a little exudation. We don't sweat, but we regret, we are very very sticky.

WE note with regret the death of Sir Frederick Gowland Hopkins. A Guy's man who later went to Cambridge, he was one of the earliest and most eminent biochemists of his time. He was President of the Royal Society, and a Copley medalist, a Nobel Prizeman, a Knight and a recipient of the Order of Merit. His contributions to medical science included the discovery and isolation of trytophan, early recognition of accessory food factors which later came to engage the attention of the whole world as "vitamins," profound and important contributions to the study of muscle metabolism, and the isolation and identification of Glutathione. We hope to publish a fuller obituary in a future issue of the *Gazette*.

THE Committee of the Hospital Chapel, whose aim it is to keep the vases constantly fitted with fresh flowers, are finding the present scarcity and high prices in London quite forbidding. The Chapel is open all day for the use of patients, visitors and staff, and the Committee ask that through the columns of the *Gazette* an appeal should be made to those people who have gardens, for help in this matter. Would any readers who could undertake to provide flowers for any particular week or fortnight (or month!) in the year, please communicate either with Miss M. Duncombe, Children's Ward, Guy's Hospital, or the Chaplain? And, where necessary, arrangements will be made for transport, etc. Any surplus flowers will be sent to the Wards or Nurses' Sick Room.

IT will be noticed that the greater portion of this issue of the *Gazette* has been devoted to a review of The Residents' Play. We have even had to cut down the size of type, which is against our policy, in order to include reproduction of the lyrics. But the revival of this age-old tradition at Guy's gave so much pleasure to all those of us who were able to attend, and was, we thought, so good, that we trust we have the approval of our readers in doing this.

The Residents' Play

THE return of the Residents' Play to the Physiology Theatre this year, less than two years since the cessation of hostilities, was a triumph for all concerned in its organisation. After the 1914–18 war four years elapsed before the Play reappeared and it was then only a short entertainment lasting 45 minutes, so that the return of this year's Play in full and glorious tradition was all the more noteworthy. Those who have attended a Residents' Play in the past do not need to be reminded of its great tradition, but nowadays, when the mention of tradition calls forth scorn and scepticism, and when there exists a large number of Guy's men and women with no knowledge of the Residents' Play, it is well to recall for their benefit some of the historical features of this unique entertainment.

The first Residents' Theatricals took place in 1901 and since that date they have continued annually, apart from the interruptions of two World Wars. By 1906 production had become so elaborate that the Play was transferred from the Governors' Court Room to its present home in the Physiology Theatre, where it has progressed steadily in complexity of production and ambitiousness. As early as 1906 the full and unique tradition of an original topical play, written and produced by Guy's men, with original music composed at Guy's, and with a cast consisting entirely of residents, was attained. The Play has continued in that form ever since. Many well-known Guy's names figure among the lists of authors, producers and composers, and year by year the Play has been acted by those men whom fate decreed to be residents at the appointed time. No other series of plays can ever have been written around a set cast, fixed by fate and not selected for ability, in which every member had to be given a part and in which men played male and female roles alike—yet so great has been the enthusiasm of these actors that they have delighted audiences with performances of high quality for nearly forty years.

Those who were privileged to see this year's Play will testify to its high standard of entertainment and production, and past audiences will be unanimous in acclaiming it the equal of any previous Play. The author, composer and producers had figured in programmes before the war, but the actors were new and not one of them had seen a Residents' Play even in his student days. Congratulations to them all! They have rendered a yeoman service in bringing about the re-birth of a particular and worthy feature of Guy's life. But Guy's men come and Guy's men go, so it is up to those who follow to take up the task in future years and, with this example, to continue a great traditional event in our Hospital. The Play is hard work for all concerned but, even to-day, hard work is fun if the object is worthy and the cause dear to one's heart. The object is to give amusement to all at Guy's and to endear old and new to our Hospital's personalities, peculiarities and mode of life; the cause is the spirit of Guy's itself. Surely a worthy enough object and surely a cause both dear to our hearts and true to our motto—"Dare quam accipere"!

This year's Play, "Wizard Show, Chaps!" or "The Corpse in the Museum," is introduced by a prologue and as the house lights dim we hear Bain soliloquising upon his own difficulties and upon the idiosyncrasies of his fellow students. He is interrupted in his meditations by the Ghost of Bright (Coupland) and the apparition of a Woman Student (Ray), the appearance of the latter causing the play to begin on a note of things to come.

The Play opens in a Medical Ward with Nurse Chlorosis, the heroine (Watson), and Nurse Marasmus (Barnes) preparing their patient (Rowlatt) for the attentions of the student multitude. Professor Ronson, the Superintendent (Ticehurst), and Sister Fright (Davys) enter the ward, Ronson proclaiming that he is working hand in glove with "Annoying Bevan" for the transfer of Guy's to the mercy of the State, and expressing his sentiments gloatingly in song:—

"IT'S GONNA BE HEAVEN WITH BEVAN."

It's gonna be Heaven,
A-working with Bevan,
At sixes and sevens
No longer we'll be.
Our poverty's ending,
We'll shortly be spending,
No further depending
On charity.
There'll be a five-day week for all physicians
who sign on the dotted line.
Pension schemes and danger money, and double
for overtime.
I tell you, moreover,
We'll all be in clover,
When Bevan takes over
Direction of Guy's.
We'll have no need to pinch and scrape,
When snugly wrapped in fine red tape,
We're going to be like angels in paradise.

Verse—
Guy's has muddled on for years,
With the help of volunteers.
Now the time has come for a change of ways.
In this Socialistic age,
Planned control is all the rage,
Private enterprise no longer pays.

It's gonna be Heaven,
A-working with Bevan,
At sixes and sevens
No longer we'll be.
Our organisation
Will be a sensation,
With representation
On the T.U.C.
We'll have a censorship to make quite certain
the teaching is all alike,
Students sit on all committees, reserving the
right to strike.
The de-population
That threatens the nation,
By co-education
Corrected will be.
Obstructions in the labour wards
Are solved by Parturition Boards.
It's really all as simple as A. B. C.

Verse—
In the days of Wilks and Bright,
Liberty was quite all right,
But it's out of date in these modern times.
Now we must co-ordinate,
Order, plan, and subjugate
All who won't agree to toe the line.

It's gonna be Heaven,
A-working with Bevan,
At sixes and sevens
No longer we'll be.
We'll make it a closed shop,
The Catering Co. stop,
Establish a Co-op.
Monopoly.
We'll banish every treatment that's Conservative,
for they're a lot of cads,
Dose of drugs must ne'er be Liberal, that's very
near as bad.
The wards here are dated
By names antiquated,
We'll have them translated
And secularized.
Both Job and John we shall condemn,
And name "Emmanuel" and "Clem."
It's gonna be a grand new future at Guy's.

Sister Fright shows proper indignation at such reactionary changes until it is time for the afternoon round. The round is signalled by the entrance of three "Air Force type" ward clerks, Prang (Amiel), Erk (Broughton), and Chuter-Lyne (Figgis), all suitably moustached, to the tune of a marching song :—

"WINGS OVER THE COLLEGE."

Prang : We are Bony's Private Army,
And our conduct may seem barmy,
But remember we've been in the R.A.F.
And a psychopathic nature
Is a very useful feature
When you're dicing in a Hurricane with
death.
At one time we were always known as
Glamour Boys,
The women swore that we were gorgeous
brutes.
But the glamour's kind of gorn,
Since we lost our uniform,
And we have to wear these dreadful
demob. suits.

Chorus :
Wings over the College !
Planes up in the sky !
We are the types that used to wear the
gongs in rows,
The chaps to whom old Winston said that
so much owes,
Now gathering knowledge
At the Hospital whose patients never die.

Prang : We have to handle stethoscopes instead of
handling sticks ;
Erk : It's fractures, not positions, that we have
to learn to fix ;
Lyne : Instead of dropping bombs we're dropping
diagnostic bricks.
All : We are the Air Force at Guy's.

Erk : Though our speech may seem peculiar,
You'd be wrong to let it fool yer,
It's a habit inculcated by the war.
If we talk of "char" and "jankers,"
Don't mistake us, please, for Yankees,
For we're absolutely British to the core.
This fungus that you see upon our upper lip
Is calculated to inspire the troops.
But we really must admit
That it interferes a bit
With the silent inhalation of our soup.

Chorus : Wings over the College, etc.

Prang : We're learning how to heal instead of
learning how to fight ;
Erk : For martial art we substitute the art of
Richard Bright ;
Lyne : Instead of baling out we learn the art of
Payling Wright.
All : We are the Air Force at Guy's.

Lyne : We are frightfully delighted
When by Bony we're invited
In to spend a quiet evening at his flat.
Where we play a little Handel,
And discuss the latest scandal,
And of Hurricanes and Lancasters we chat.
Before the war his parties were notorious,
They were, to put it mildly, pretty bright.
But of Bony we can say,
Alcoholic in his day,
He has now become a very sober Knight.

Chorus : Wings over the College, etc.

Prang : We're learning Price's Medicine now
instead of Morse's code ;
Erk : And how to tell the difference 'tween a
pimple and a node ;
Lyne : And how to stand beside the bed just like
an Air Commode.
All : We are the Air Force at Guy's.

The song over, Sir John Bonnybear, an "Air-borne Physician" (Hammond), and his H.P. (Jack T. Tate, the hero, played by Crossley), are greeted in true R.A.F. style by the "chaps." At the end of the round we hear that Mr. George Shirty, the Deputy Superintendent, has not been seen for a week, and Chlorosis re-enters with the news that Nurse Marasmus has also disappeared. The worst is suspected but the audience senses something sinister in these happenings. On learning that George has vanished the "types" immediately suggest Bony as "Super," and we are then introduced to

the theme of plotting for control of the Hospital by obtaining that coveted office as Bony sings :—

"IF I WERE THE SUPER OF GUY'S."

Bonny : When I was in Mespot in nineteen-sixteen,
I learned discipline from the Army.
This war, as you know, in the Air Force I've been,
And folks say it's made me quite barmy.
But that's where they're wrong, for when I look at Guy's,
And see what a terrible mess it's in,
It seems plain to me that the remedy lies
In a spot of the old Service discipline.

Omnes : If he were the Super of Guy's, boys,
If he were the Super of Guy's.
He'd make the old hospital hum, by Gad !
Everyone under his thumb, by Gad !

Bonny : I'd issue directives and orders,
For treatments that I think are wise ;
No tonsil removal without my approval.

Omnes : If he were the Super of Guy's, boys,
If he were the Super of Guy's.

Bonny : It's quite clear to me Guy's has gone to the dogs,
(Metaphorical, not the White City's),
There's far too much faction and rolling of logs,
And too many blasted committees.
Democracy really is quite out of date,
(A fact that I learned out in Mespot),
And what we need here is an organised state,
With me as Benevolent Despot.

If I were the Super of Guy's, boys,
If I were the Super of Guy's.
I'd make the old hospital hum, by Gad !
Everyone under my thumb, by Gad !
The cads who were not in the Forces,
Such decadent types I despise.
They'd get no promotion *this* side of the ocean,
If I were the Super of Guy's, boys,
If I were the Super of Guy's.

Omnes : If he were the Super of Guy's, boys,
If he were the Super of Guy's.
He'd make the old hospital hum, by Gad !
Everyone under his thumb, by Gad !

Bonny : And students on duty found talking
To nurses with naughty blue eyes,
Would be on the mat in my office for "frattin",

Omnes : If he were the Super of Guy's, boys,
If he were the Super of Guy's.

With the plot opening before us the stage clears and our Hero and Heroine are left alone, apart from the patient tactfully concealed beneath the bedclothes, to sing their love duet :—

"YOU'RE MY PANACEA."

Jack : Darling, I can't get along without you,
When you're gone I feel as low as hell.
Guess you've got some magic touch about you,
When you're near my system functions well.
Martindale I've thrown into the fire,
You're the only medicine I require.

You're my panacea,
My elixir for diarrhœa, oh
You're specific for my failing heart.
You're my oxygen,
My cincophen, my dose of senna
You're the crisis in my temperature chart.
I never knew that love could be like this,
This is a new one on me.
I'm going to write myself a dose of bliss
T.D.S. both A. and P.C.
You're my Mothersill,
My magic pill, my penicillin,
You're the acme of the chemical art.

Chlor : I feel so contented when you're near me,
Like a kitten purring by the hearth.
Through life's care and troubles you will steer me,
My perfect man, my Hercules, my Garth !
I'm completely underneath your spell,
You're my prop, my rock, my Citadel.
You're my cup of tea,
My T.C.P., my A.P.C., oh
You're the ointment on an itching spot.
You're boracic lint,
My Thomas splint, my oil of winter-Green. You're better than a hot-water bott.
All other glamour boys you supersede,
You are my light and my star.
I'm here to give you all the love you need
S.O.S. and pro re nata,
You're my thermogene,
My benzedrine, my morning Eno's,
You've got something that the others have not.

Chlor : You're my Soda Bic,
My Mist. Ol. Ric, my dope addiction,
You're just everything that I hold dear.

Jack : You're sulphonamide,
My Student's Guide, my G.I. bride, oh
You're the froth upon my favourite beer.

Chlor : You are the dream of every lovesick gal,
All your ingredients are pure.

Jack : You are the Sodium and I'm the Sal.,
Let's get together and shake the mixture.

Chlor : You're my laughing gas,

Jack : My felix mas, my folic acid,

Both : You are the contents of the Pharmacopœia.

Dr. Horace Shamble (Crabtree) comes to visit Stripsem and is duly impressed by the pathologist's powers of detection. Miss Amanuensis, Stripsem's secretary (Maxted) announces that Bony's H.P. is seeking an audience and our Hero informs Stripsem of the mysterious smoke signals. Scotland is concerned that some of his specimen jars contain new and unidentified parts—can they be the remains of George, or Nurse Marasmus, concealed there by some evil-doer ? Stripsem decides to solve the mystery without the aid of the Yard, and, with Shamble and our Hero, wastes no time in getting down to work.

The next scene, in the Furnace Room of the Work's Department, introduces the stokers (Barnes, Eastes and Everall) singing and dancing to the tune :—

" WE'RE THREE HONEST STOKERS."

Verse—
We're three honest stokers,
We shovel by shifts.
Producin' of the juice,
For the lights and the lifts,
If you come to London,
And want to find Guy's,
Don't ask a perliceman,
Look up to the skys.

Chorus—
Smoke—dust—rake out the flues,
Spit on the clinker and swill down the booze.
Bert, Bill, and Joseph are earning their pay,
Sending the smoke up the chimney all day.

Verse—
It's the minister of fuel,
What doles out the muck,
And our Mr. Shinwell,
He don't have no luck,
The coal is half clinker,
The other half's slate,
It smokes up the chimney,
But won't warm the grate.

Verse—
The steam pressures falling,
In spite of our toil,
The engines want oiling,
The water won't boil,
So when in the daytime,
The lights burn too low,
Don't blame the poor stokers,
Not Bert, Bill, nor Joe.

The amorous scene is concluded by the reappearance of Sister, still searching for the missing Nurse Marasmus. Our Hero notices the Hospital chimney bèlching smoke in an unusual manner and reads into it a message in Morse. The disappearance of George Shirty is confirmed and Chlorosis begins to act mysteriously. The Hero senses mischief at work and determines to unravel the web of intrigue. The plot thickens !

Scene 2 shows us Dr. Heath Stripsem a " Forensic Furore " (Bain) and his assistant Scotland (Burns) at work in the Museum. Stripsem reveals his manifold activities and Scotland draws him into song :—

" MURDER IN MAYFAIR."

Attention, I will now disclose,
Forensic skill is not what you suppose,
And so without excuses or apology,
Here is the low down on Police pathology.
My object's not at all sublime,
I'm not concerned with punishment or crime,
But simply this,
My secret I unfold,
The way I've found to eminence and gold
Beneath a cloak of scientific skill,
I sort the P.M. findings as I will.
Come murder, rape, a suicide maybe,
The cause of death it matters not to me,
My private views, are never in the news,
The truth—I never heed,
For fear the judge and jury it mislead,
Here is my star, my ever guiding light,
No matter how, the cops are always right.

Murder in Mayfair,
Murder in Mayfair,
Scotland Yard investigates
The latest crime,
Strangled with her stocking,
Other details shocking,
Body in the basement,
In a bath of lime.

Murder in Mayfair,
Murder in Mayfair,
Send for Doctor Stripsem,
When you're out of clues,
Find it quite amusing
Faking up the bruising,
Pictured in the Standard,
And the Evening News.

Murder in Mayfair,
Murder in Mayfair,
Scene in the Old Bailey,
Stripsem in the box,
Pseudo-scientific,
Evidence terrific,
Pitying the jury that I'm
Out to fox.

Murder in Mayfair,
Murder in Mayfair,
Circumstantial evidence,
Someone's for the drop,
Scotland Yard delighted,
Soon I shall be knighted,
There's no other method,
If you'd reach the top.

Stripsem, Shamble and the Hero, appear and begin interrogation, but get no help from the chief stoker. Approaching footsteps tense the atmosphere but it is only Dr. Grunt (Munro) engaged upon a research problem on heat production. He tells the company about his scientific experiments in a broad Scot's accent :—

" I'M A SCIENTIFIC WALLAH."

Grunt—
I'm a scientific wallah,
And a seeker after truth.
Research is what I follow
With the grimness of a sleuth.
I note with some derision
That the practice of physicians
Is lacking in precision,
And quite devoid of truth.
Their habit is to draw deductions bold
From data absolutely uncontrolled.

My attitude is cynical
To observations clinical,
I find they are inimical
To honesty of thought.
Too often metaphorical,
Or frankly allegorical,
They're like the Delphic Oracle,
And mean precisely naught.

Chorus—
His attitude is cynical
To observations clinical,
He finds they are inimical
To honesty of thought.
We say with some asperity
That those who have temerity
To criticise its verity,
They really didn't ought.

Grunt—

For the bedside observations
Of such men as Richard Bright,
I confess to admiration,
For they often turned out right.
But by standards modernistic
They are quite anachronistic,
For their knowledge of statistic
Was unfortunately slight.
If for scientific laurels you would try,
You must get the gen about the square of Chi.

My attitude is cynical
To observations clinical,
I find they are inimical
To scientific fact.
All statements hyperbolical
On matters metabolical
Are simply diabolical,
Exactitude they lack.

Chorus—

His attitude is cynical, etc.,
It's really most commendable,
His standards are unbendable,
And *his* results dependable,
By mathematics backed.

Grunt—

Now if errors scientific
You desire to circumvent.
There is only one specific,
The controlled experiment.
And it fills me with depression
When I listen to expression
Of a " clinical impression,"
For it isn't worth a cent.
Though your patient may start leaping out of bed,
That doesn't prove he isn't really dead.

My attitude is cynical
To observations clinical,
I find they are inimical
To clarity of view.
Of dogma theoretical
I'm always very sceptical,
My answer's dialectical,
" Now is it really true ? "

Chorus—

His attitude is cynical, etc.,
And those with the audacity
To question his capacity
For absolute veracity,
Are really very few.

Grunt—

Well, I hope that this recital'
's helped to open up your eyes.
And the points I think are vital
I'll attempt to summarise.
Define your terms of reference,
Control your work for preference,
To scientists show deference,
For Science never lies.
And the moral of this simple little song ?
In a nutshell—The Clinician's Always Wrong.

My attitude is cynical
To observations clinical,
I find they are inimical
To singleness of mind.
And scientific ritual
Should always be habitual,
For if you follow it, you all
Serenity will find.

Chorus—

His attitude is cynical, etc.,
We'll throw away our stethoscopes,
And learn the scientific ropes,
On Dr. Grunt we pin our hopes,
The Scottish Master-Mind.

But this explanation of his presence in the Furnace Room does not convince Stripsem, who suspects him of doing the signalling, and the sleuths decide to continue their investigations elsewhere.

Chlorosis enters the empty stage furtively and is approaching the furnace door when she is surprised by the reappearance of the Hero. She cannot explain her presence in this unusual place and is pleading for her lover's trust when Ronson catches them red-handed. Stripsem and Shamble return and exonerate the Hero, but Chlorosis is saved further explanations by a noise in the furnace. Stripsem thinks he has caught the miscreant when the furnace door opens and a figure in asbestos clothing emerges—but again it is only the erstwhile scientist, Grunt, still researching, and we reconcile ourselves to an anxious interval with the plot still unsolved.

The second act opens in the Out-Patient Department with three nurses, Ranula (Humphrys), Cannula (Crook) and Scrofula (Ray), telling us in verse of their worldly experiences before coming to Guy's :—

" I'VE GOT A YEN."

Cannula : I was in the A.T.S.,
Four long happy years.
Popular in every mess,
Pet of the pioneers.

I was an A.T.,
Not that it matters now,
Nobody flatters now,
My face.

In Monty's eye,
I was his pin-up girl,
He noticed every curl,
In place.

Dance at the Ritz with the Lancers,
Visiting Brigadiers flats.
Officers messing girl at Poona,
And gorganzola to the Desert Rats.

A junior Pro,
Illusion shattered now,
A trifle battered now,
Disgrace.

Ranula : Used to be a little Wren,
Was a rakish craft.
Always convoy for the men,
Liked my fore and aft.

I've got a yen,
To be a Wren again,
To meet the men again,
Some way.

Please understand,
I'm under-manned again.
No longer canned again,
All day.

Can't put the sex into sextant,
Forgotten the smell of the brine,
Can't put the vice into Admiral,
I'm no longer his magnetic mine.

I'd like to sail,
Beyond the pale again,
With my male again,
I'd try.

Scrofula : Wish I'd never left the Waaf.
Miss those bomber crews,
S'pose there's something wrong with me,
I've got those nursing blues.

Back on the drome,
Somewhere in France again,
To have the chance again,
To fly.

I'd love to roll,
Get in a spin again,
Involved in sin again,
Or try.

I was the reason for Radar,
Always the target for to-night,
Flying was never so blind for me,
I was always in the bombers' sight.

I'm losing height,
I've shed my wings again,
They're changed for strings again,
But why ?

Dr. Grunt, with his " Back Room Boys," Bolling (Everall) and Blackardle (Burns) arrive to conduct a session and the much-abused 'Arry 'Opkins is referred to them for investigation. A fugitive patient from York Clinic interrupts the proceedings but Grunt is not to be deterred and 'Arry is subjected to the tortures of weird electrical apparatus in the interests of scientific study. 'Arry's final rejection of the offer of further treatment, in good old Borough language, is shrouded in a black-out.

A front-stage " drop " takes us into the Park and we return to the plot. Grunt joins Mr. Readily Ratkins (Kynaston) and Sir Ullage Ogleme (Coupland) and their conversation turns to the missing " George." Ratkins reveals that he, too, is interested in succeeding Ronson as Superintendent. Ugleme thinks that Bony will stop at nothing to get the job, and announces that he himself is much too busy to have any time for Guy's. In the trio that follows, Ugleme and Ratkins preen themselves, offset by the dour Grunt :—

" I'M A V.I.P."

Ogleme—
In Demerara, Durban and Dahomey,
In Fuenterrabia, Florida, and Fife,
You'll find that all the cognoscenti know me
As Ogleme, the Wizard with the Knife.
My name is one to conjure with in Kenya,
At Darien it causes wild surmise.
I'm at Timbuctoo to-day, and to-morrow in Bombay,
And occasionally you'll find me here at Guy's.

I'm a V.I.P.,
A tremendous swell,
I'm a K.B.E.
And I'm important as hell.
Until recently
I was a General.
But I'm really quite a reasonable surgeon as well.
When I operate
On a case of piles,
People congregate
To see my marvellous styles.
If you think I'm staid,
You'd be wrong by miles—
You should see me do the rumba when I'm out on the tiles.
At week-ends you will always find
Me sailing in a boat upon the billows.
A sport considered most refined,
And patronised by awfully decent fellows.
I'm a leading light
Of the R.C.S.
And a constant writ-
-er in the medical press.
Now I think it right
That I should confess
That to Pelmanism, gentlemen, I owe my success.

Ratkins—
I'm the new-appointed surgical Director,
And they say that I'm the hospital's white hope.
Than *my* instruction there is none correcter,
For I'm a dab at dishing out the dope.
I sit on all executive committees,
My finger is in all important pies.
And I've heard the chaps declare
That if Ratkins wasn't there,
They really couldn't go on running Guy's.

I'm a busy bee,
I'm a real live wire.
Keep an eye on me,
I'm a do-er or die-er.
It's a certainty
That I'll rise still higher,
And at any moment now I'll set the river on fire.
I am slim and tall,
And my looks compel
Every nurse to fall
'Neath my masterful spell.
It's agreed by all
That my work excels,
And they tell me that I'm absolutely charming as well.
Now, has your face gone all awry ?
And is your little finger anæsthetic ?
I fear that your blood pressure's high,
You'd better let me cut your sympathetic.
I'm a coming man,
I'm a future Lane.
Though I'm rather grand,
Yet I'm not really vain.
And my name will stand
In the Hall of Fame,
If inspiring you're requiring, Redley Ratkins' the name.

Grunt—
Let others have the honour and the glory,
And bang the drum and mak' a lot o' noise.
I'm happy in my simple laboratory,
A working with my lassie and my boys.
I'm a mixture of a hermit and a boffin,
My habit is to shun the world of men.
I'm a sort of anchorite, or a learned troglodyte,
But at least I am the Monarch of my Glen.

I'm a muckle Jock,
I'm a cautious Scot,
And I know what's what
On the subject of Shock.
Let the heathen mock
That I'm an awful swot,
But I've got a little science that the others have not
I'm no devotee
Of this push and go.
With the M.R.C.
Life is peaceful and slow.
If you're asking me
What my researches show—
I've forgotten 'cos they started such a long time ago.
I've spent my time for years and years,
Cutting my experimental capers.
You'd wonder why no work appears,
But I never get the length of writing papers.
First you start off strong,
And you sweat and strain,
Then you find it's wrong,
And you do it again.
After labour long,
You find the work's in vain,
And you stuff the whole caboodle down the laboratory drain.

Our trio depart and Stripsem, Ronson and Shamble return with the mystery of George and Nurse Marasmus still baffling them. Chlorosis rushes in with the news that Marasmus has been found in the Park and Stripsem's problem of the "parts" in the jars is solved—they must be those of poor old George! Ronson tells him it's nonsense and departs with Chlorosis, but Stripsem and Shamble are on the scent and proceed to examine their list of suspects. Grunt, Bony, Ratkins and Ronson himself come under the cloud and our crime experts leave to pursue their investigations.

Bony appears on the scene, well pleased with the progress of his campaign for Superintendentship, and, as he espies the fair Chlorosis, makes love to her in word, action and song :—

"YOU'RE PARADISE FOR ME."

Bony : In this domestic crisis,
My exceptionally good advice is,
Don't try to look,
You'll never find a cook.

Batchelors must be protected,
So this little plan I've just perfected.
I'll take a wife,
She'll be my char for life.

You're paradise for me,
Why can't you realise how nice I'd be,
Just name the day right away.

Chl. : I think you're very bad,
You're old enough you know to be my dad.
You'll never get me that way.

Bony : Picture an evening,
Holding hands while gazing at the television.

Chl. : Cut the deceiving,
Nothing you can offer sir will alter my decision.

Bony : You've got no enterprise,

Chl. : Perhaps I've learned a little since I came to Guy's.

Bony : Why don't you say. . . *Chl. :* I'll never say.

Both : It's O.K.

Chl. : I've got my own ambition,
Quite uninfluenced by his position,
I'll never fall,
He's not my type at all.

Bony's no simple lover,
What his motive is I can't discover,
Such an idea.
Me—Lady Bonybear.

Chlorosis, true to her heart, resists the temptations of wealth and title, but Bony, finding she is betrothed to another, tells her he has discovered her guilty secret. Bony summons his loyal R.A.F. clerks who arrive with typical noise and gibberish. Dai Evans (Downes) recognises Chlorosis as none other than the daughter of the famous "Annoying Bevan," sent to Guy's as her father's spy! The curtain falls with our Heroine now under the cloud of suspicion.

In the next scene we discover that Chlorosis has been abducted to Bony's flat where she is being kept until she consents to become Lady Bonnybear or until her father pays ransom by installing Bony as Führer of Guy's. Our Hero discovers her and climbs in through the window of the flat. Comforted in his arms she confesses her identity and obtains forgiveness, whereupon the Hero takes steps to free her from captivity :—

"BACK TO THE BOROUGH AGAIN."

He : Darling!
She : Yes, darling?
He : Nothing darling, just darling, darling.
She : Honey!
He : Yes, honey?
She : When you kiss me I feel quite funny.
He : It's high time that we got wedded.
She : In Bill Shakespeare's words—you've said it!
He : Let's get spliced in June.
She : And have a really wonderful honeymoon.

She : Oh we'll take a train
Or a ship or plane
To Cairo or to Algiers—

He : Darling, don't talk rot,
For the cash I've got,
Won't take us further than Southend Pier.

She : Shall we call at Rome,
Or take in Stockholm,
As our way to Moscow we wend?

He : With a bit of graft
On my overdraft
We might have a day at Ostend.

She : Oh, darling, I feel so romantic,
The world is open and free.

He : I don't want to appear pedantic
But there's just a little matter of L.S.D.

She : Though the outlook's grey,
There will come a day
When we'll build our castles in Spain—

He : But right now, my dear,
They're a dream, I fear,
And we're back in the Borough again.

He : Angel!
She : Yes, angel?
He : Nothing, angel, just angel, angel!
She : Poppet!
He : Yes, poppet?
She : I'm fibrillating and I just can't stop it.
He : I propose that we get married
She : Motion seconded and carried.
He : Then we'll settle down
She : In a pre-fabricated house in London Town.

He : Oh in Harley Street
All the nobs you'll meet,
But they're too expensive for us.

She : Oh, they say it's fun
Out in Wimbledon,
But it takes simply ages upon the 'bus.

He : It would be a lark
Up in Belsize Park
But I fear my nose is too straight.

She : If we had a maind
To be quate refained
We might live in Lancaster Gate.

He : We might go down to live at Purley
Or take a cottage at Cheam.

She : My dear, you'd have to rise so early,
I can't believe you'd ever make the 8.15.

He : Well, we've been all round
And about the town
But it seems our search is in vain.

She : So we'll turn our feet
To St. Thomas' Street
And come back to the Borough again.

She : Oh where'er you go
You will find, you know,
That the good old Borough is best.

He : I know it's flat
But in spite of that
The Borough's head and shoulders above the rest.

She : To the Borough folk
Life is just a joke
They're gay and simple and sane.

He : And the chaps that made
Adolph Hitler fade—
Well, they're back in the Borough again.

She : I like the noise and cheerful clatter,
I like the pubs and the shops—

He : I like the sound of Cockney chatter
I simply love the all-pervading smell of hops.

She : When you qualify
Far away you'll fly
But you'll find you've journeyed in vain.

He : When you're old and grey
You'll return some day
And come back to the Borough again.

Both : When we're dead and gone to glory
And get leave from Purgatory
We'll come back to the Borough again.

After this duet Chlorosis assures Jack she is not mixed up in the murder of George, but she will not disclose with whom she is in league at Guy's. Jack sees the chimney smoke signals again and Chlorosis tells him that her confederate is sending secret messages to the Minister of Health. Our Hero hastens to the Furnace Room to catch the villain at his work.

As the curtain rises on the final scene we see a dreadful sight. Ronson has Ratkins bound and gagged in the Furnace Room and is about to feed him alive to the flames of the furnace, so creating more smoke for a further message to Bevan ! Thus Ronson is revealed as the arch-demon. He has murdered George, is now proceeding to get rid of Ratkins and will then deal with Bonnybear. He is disposing of all his rivals and then, with the help of Bevan, will become Lord Bermondsey, the Labour Dictator of Guy's !

True to tradition our Hero arrives in the nick of time and, supported by Chlorosis, Stripsem, Shamble, Ogleme, Bony and the R.A.F., saves Ratkins from a living death. Ronson offers armed resistance and in the struggle which ensues he disappears through the open furnace door into the grave intended for his second victim !

Stripsem considers this another forensic triumph but Chlorosis claims Jack the Hero and the company applaud his prowess. The Hospital has now lost its Superintendent. Shall his successor be Bony or Ratkins ? This problem is solved by the entrance of Mr. Seas-Weed, the Clerk to the Governors (Maxted) who announces in well-known accents that the Governors have decided on a " young chap " and who better could fill the post than Dr. Jack Tate, our Hero ! So Guy's (Jack) and the State (Chlorosis) are truly united. For Jack at any rate it will be " Heaven with Bevan " and the curtain falls on a reprise of that memorable tune :—

" FINALE."

Omnes : It's gonna be Heaven
A-working with Bevan,
At sixes and sevens
No longer we'll be.
The collaboration
Of Guy's with the Nation,
Will mean the creation
Of History.
Poor old Guy's was badly battered by Hitler and all his crew,
Like a phœnix from the ashes will rise a Hospital new.
Our ancient tradition
Will gain by addition
Of solid nutrition
From Country and State.
And now there's nothing more to say,
We hope you have enjoyed the Play,
We'll say Good-bye till Nineteen Forty-Eight.

So ended a play most excellently played. John Forbes, the author, wrote a good play in 1939 but an infinitely better one this year. The main and subsidiary plots were excellent, they were skilfully woven together, and their unravelling in the last scene was smooth and unsolicitous. No embarrassing passages of explanation were required and the script throughout was both entertaining and humorous. It contained an

unusual number of trite remarks and showed an insight into Hospital affairs which we have come to expect from the author of a Residents' Play. The personalities due for public exposure this year must have been relieved that their medicine was dispensed in such a palatable form. For it was a kind play, pointed and pointing but never malicious, and the author avoided being carried away by his theme to such an extent that some people thought he could have taken it further without undue hurt to anyone's pride. Congratulations to Forbes on restarting the Play at a level which will be difficult to maintain, for it is only with such a stimulus that authors of the future will come forward to do their best and give us what we all desire—another Residents' Play.

The music of Tom Hills was of a standard even surpassing his previous achievements, and its wide range surprised those who had not heard his compositions before. Authors are hard to unearth but composers are worth their weight in gold, and if Hills is serious in his threat of retirement the Residents will be sorely tried to find a worthy successor The music was played by Prosser and Tomes at two pianos and we are grateful to these newcomers for their tuneful and harmonious renderings. The lyrics by Forbes and Hills were good and witty, and " got over " with outstanding success, but occasionally one felt they demanded a little too much from untrained vocalists.

Now what of the actors ? Without exception they all did remarkably well. They were at home on the stage and at home in their parts. Their diction was clear and their rehearsal so thorough that prompt side was completely silent. In such a cast it is almost invidious to give special praise but some of the characters were so well played that it would be unfair to deny them a notice. Hammond's Bonnybear, Bain's Stripsem, Crabtree's Shamble and Ticehurst's Ronson were life-like studies. Munro's Grant was a splendid performance and though his accent was a little exaggerated his enunciation of a difficult lyric was magnificent. Of Coupland as Ogleme and Kynaston as Ratkins we should have liked to see more. Jack T. Tate was excellently played by Crossley. His voice was good and he carried off the embarrassing role of Hero without shyness. Watson as his Heroine was equally good though at times a trifle coarse in mannerism. Rowlatt's 'Arry 'Opkins was a perfect portrayal of the Borough patient and his antics in bed delighted everyone. A Residents' Play would not be complete without a nurses' chorus and the trio of Humphrys, Crook and Ray thoroughly deserved their encore. The other combined effort of outstanding merit was the performance of Amiel, Broughton, Figgis and Downes as the " Air Force types," and this feature was one of the high lights of the show.

The production of the play was in the capable hands of Forbes and Hills. Producers are born, not made, and that these two were born to their job was evident for all to see. They had trained their team to perfection and share the praise which is due for the smoothness of performance. On a small proscenium they moved their actors about with skill ; their curtains were good ; and their hard work and strict discipline at rehearsal was rewarded by a stage display of high quality. When Forbes and Hills join the select band of past-producers their advice and help will be fervently sought by those who take over their onerous task. The stage manager, Willie Maile, and his group of faithful followers, served the producers with zest and zeal, and they also share the credit for the success of the Play. The scene changing was rapid and inaudible, the effects were good and there was no breakdown in the supply of " props." The scenery was again painted by A. Farmer, of the Works Department, and was up to its usual standard. This year, however, we saw a smaller number of " drops " and less elaborate lighting and effects. Austerity was also detectable in the absence of " flats " and footlights. A small criticism may be offered of the make-up, for it lacked polish in some parts and powder in others. If nurses' uniform continues to have short sleeves the unfortunate " females " must be made to shave their arms—that would be a small sacrifice compared with the shaving of Stoneham's massive torso for his celebrated ballet dance in 1939 ! The wigs were sometimes untidy and in one or two cases were not up to standard, but this again was due to the austerity restrictions imposed upon the Residents and producers. The Play is too fine an institution to be skimped in the smallest detail for the spending of a little extra money. Is it too much to hope that the audience will also banish austerity in 1948 ? The " white tie " is not a creation of Guy's but it can be claimed as a custom of good old England transported to Guy's for a special occasion ; and, whatever reactionaries may say, it not only looks nice but is an appropriate sartorial recognition of the merits of the Play. Good luck to the Residents of the future , long life to the Residents' Play !

S.H.W.

Correspondence

Nursing in Newfoundland

The following letter has been forwarded to us by the recipient, thinking that it might interest our readers. We think it will.

DEAR—, If I don't write now you will not get this until sometime in June, because the thaw will soon be setting in and dog-team travel will not be possible. On the other hand, the boats will not get round until early June. However, don't be discouraged from writing yourself! By the time this reaches you and you have answered it navigation will just about be starting. 30° below zero was the average temperature for January, but even so, I can't say I have felt cold all the winter.

The matron went on vacation leaving me in charge? Well, she is not coming back and they have asked me to continue with the job. The housekeeping is a terrific job. There is always so much canning to do because the seasons for different things are so short. At the moment we are faced with canning seal if we can get enough. Then in June and July there will be the everlasting salmon to put up for the winter. And in the autumn all the different kinds of berries.

Nursing has been quite a problem. Besides myself there were only two American nurses, neither with any obstetrical experience, and I have had to give all the anæsthetics because there is seldom more than one doctor here at once, and if there is there is the second one usually prefers to assist. Often our surgical team consists of one nurse as assistant, one 17-year-old Newfoundland aide as scrub nurse, and me to give the dope, and this for major operations like Cæsareans. It is great fun, and we get on very well ogether and so far everything has turned out well. During the school holidays we do ten and eleven tonsils each morning!

One of the nurses I came out with has gone to a nursing station in Labrador with only one person to help her—a very nice social worker with absolutely no medical knowledge. They both have a great sense of humour and we hear some very amusing stories of their experiences. The social worker gives anæsthetics for forceps deliveries and minor surgical operations. Like most amateur anæsthetists she is afraid to give much ether and the patients never go further than the second stage so the whole performance is accompanied by much singing and shouting. The first case she ever did went under saying he felt " safer than in the arms of Jesus."

The other morning at 6.0 a.m. a call came for someone to go to a midder case ten miles away, so I took it. The journey was magnificent; the weather was bright and sparkling and the dogs were in good form. When I got there I found a primip on the second stage with uterine inertia. There was no distress either maternal or fœtal, so I decided to wait. As the afternoon went on I began to think of putting on forceps as her sister was a sensible person who could easily have maintained the anæsthetic once I had done the induction. However, the mother-in-law suddenly had an idea. With one of her labours she had had an inertia because she wanted a cup o' tea with cow's milk, and when at last it had been produced she bore her baby! So I asked the patient if she had any particular craving and she said, " Yes, a hard fried egg." So I thought, " Try anything once," and told her sister to get it ready. I then went and sat downstairs while she ate it, when suddenly there was a grunt and a shout; I ran upstairs and the head was showing; six more good pains and the baby was born! Now, that is the honest truth, and I think Mr. Gibberd should be told and have it added to his book, don't you?

The winter has surpassed my wildest expectations. It has been one joy after another. Ski-ing has been the greatest fun and I am beginning to jump now. We go for wonderful cross-country skis, and I have now got to the stage of finding that I can cope with almost any hill in the district—both up and down.

(Signed) P. M. ROWBOTHAM,
Grenfell Hospital,
St. Anthony,
Newfoundland.

Bicycles

SIR,—The lobby of Sophie's Hostel is embarrassed with many old and unused bicycles. I crave the hospitality of your columns to ask any owners who have graduated from this establishment and left the Hospital to remove their machines during the next month if they wish to retain them either for use or sentiment. The remainder will then be removed to make room for present owners.

Yours, etc.,

CHARLES BAKER.

Warden's House,
Guy's Hospital, S.E.1.

Urea and Other Things

SIR,—In the *Gaxette* of 29th March, Dr. Kirkland describes his interesting accidental discovery of the value of urea in the treatment of "migraine," but an inevitable wet blanket came in the following issue from Dr. Douthwaite. I, too, used urea in some cases in military wards recently, but with only moderate success.

Urea is Nature's diuretic—has to be to get away. It is interesting to reflect that it is the base in barbiturates and that "migraine" has much in common with "epilepsy."

Sir Cooper Perry used to say he never employed a drug until it had proved itself for ten years: consequently he used very few. Professor Trousseau, on the other hand, began his lectures with: "Gentlemen, make haste to use a remedy while it has power to cure!"

Why this difference? Why do we expose our incapacity so constantly by the unseemly pursuit and praise of new nostrums? Why are Dr. Kirkland's results so much better than mine with urea? (Mine were not so bad when military incorrigibles suspected they were taking essence of urine).

Somewhere about 1900, a young philosopher with a beard read a paper at the Guy's Physical Society entitled "What is disease and what are diseases?" Four Guy's great Victorians were there. They looked, if I may say so, rather silly—balked. No definition of disease was forthcoming from them. None ever can be from anybody.

Plato jibbed at the same hurdle: bars marked alternatively ideal and material, subjective and objective, or concept and percept: gaps not to be bridged this side of Styx.

"A" allergic perhaps has hemicrania, sees sparks not there and vomits. "B" binged, bumps his head and has ditto. Medicine classifying ever and invoking cause, flounders, while Physics soars on nebulous wings of relativity and probability into the stratosphere perhaps.

It seems to me the superphysician does not diagnose much. B.C. a thousand or more the Chinese tried to push the art to a logical conclusion, listed 10,000 varieties of fever and were bogged in consequence.

Not only are there as many ideas as men, but as many diseases. The individual is unique: his disease his personal affair—and what he wants from us is a boost to get him into tune again with his environment and not to be classified (which he abhors) or diagnosed (which he can ill afford).

Man has risked much with some virulent things lately—organic arsenic—emetine—sulphonilamide, but we seem to be getting down to bedrock with penicillin and streptomycin products of the earth—earthy as we are.

That Nebuchadnezzar recovered at grass, ceased to dream dreams, governed a great empire with vigour and sense, is a basic hint in therapeutics, for you and I can get along with very little doctoring if we grow and eat our own food in situ under the vault of heaven and are tolerant of viruses, bacteria, worms and men as nature intended us to be.

Yours, etc.,

H. F. B. WALKER.

Fort Armstrong,
Balfour, C.P.,
S. Africa.

Hospital Information, etc.

NOTICES

GUY'S HOSPITAL STUDENTS' UNION

The Bi-Annual General Meeting of the Guy's Hospital Students' Union was held on Wednesday, May 14th, in the Physiology Theatre.

Mr. Leonard Jacobs and Mr. Jack Palmer were re-appointed Chairman and Hon. Secretary respectively, their election being unopposed. The meeting passed two amendments to the Students' Union constitution, one providing for the re-allocation of dental representation on the Students' Union Council so as to include Pre-Medicals and the second increasing the officer's term of service from six months to twelve.

In his report the Secretary gave a detailed account of activities during the recent months. Three dances at outside halls had been arranged, talks had been given by Mr. R. C. Brock and by Mr. Stuart Hibbert. A Brains Trust, including Mr. C. B. Fry, had been held. The Students' Union Council had also carried out many jobs in its capacity of representing the student Body to the Medical School and Hospital Authorities. Most notable of these had been the organisation by the S.U.C. of the Students' Blood Donor Scheme. It was also announced that the Students' Union Office in the Old Path Block is now open from 12.30–1.30 daily for enquiries, sales of tickets, etc.

The meeting concluded with a general discussion of plans for the Summer Term and for the coming year.

JACK PALMER,
Hon. Secretary, G.H.S.O.

DEPARTMENT OF SURGERY.

On Saturday, June 14th, at 10 o'clock, Mr. Wass will be conducting a Departmental Round in Lydia Ward.

On Tuesday, June 10th, at mid-day, there will be a further demonstration in the series "Operative Procedures" in Theatre 2.

H. J. B. ATKINS,
Director.

DEPARTMENT OF ANÆSTHETICS.

Mr. Marston will give a demonstration on "Open" Methods of Administration of Anæsthetics in *Theatre II at 12 noon on Tuesday, June 17th*, 1947.

A similar demonstration will be given on alternate Tuesdays until further notice.

Senior Medical Students wishing to attend should leave their names in the Medical School Office.

WILLS LIBRARY.

The periodical "THORAX," 1947, Vol. 2, Part 1, March (current number), has been removed from the Reading Room and as its absence is causing much inconvenience to other readers, it is requested that it should be returned at once to the Librarian.

GUY'S HOSPITAL MEDICAL SCHOOL.

Applications are invited for the appointment of Assistant to the Director of the Department of Medicine. The appointment is for two years in the first instance, to commence as soon as possible. Applicants should hold the M.D. or M.R.C.P. Salary £750–£1,000 per annum, with superannuation and family allowance. Copies of Standing Orders for the appointment are obtainable from the Dean to whom ten copies of application, with the names of three referees, should be forwarded not later than 14th June, 1947.

Applications are invited for the appointment of Assistant to the Director of the Department of Surgery. The appointment is for two years in the first instance, as from 1st September, 1947. Applicants should hold the M.S. or F.R.C.S. Salary £750–£1,000 per annum, with superannuation and family allowance. Copies of Standing Orders for the appointment are obtainable from the Dean to whom ten copies of application, with the names of three referees, should be forwarded not later the 14th June, 1947.

Applications are invited for the post of Chief Clinical Assistant and Registrar in the Ophthalmological Department. Duties to commence immediately. Honorarium to be at the rate of £105 per annum, for attendance on one session per week. Forms of application are obtainable from the Dean, Guy's Hospital Medical School, to whom applications, with the names of three referees, should be forwarded at once.

JUNIOR STAFF APPOINTMENTS.

Applications are invited for the Junior Staff appointments listed below for the session 1947–48. Forms of application are obtainable from the Medical School Office and should be lodged with the Dean not later than 14th June, 1947.

Tutor in charge of the Preliminary Clinical Period Class.	(1)
Medical Registrar.	(4)
Surgical Registrar.	(2)
Clinical Assistant in the Department of Diagnostic Radiology.	(2)
Clinical Assistant and Registrar in the Ophthalmological Department.	(2)
Chief Clinical Assistant and Registrar in the Dept. of Psychological Medicine.	(1)
Chief Clinical Assistant and Registrar to the E.N.T. Department.	(1)
Chief Clinical Assistant and Registrar to the Dept. for Nervous Diseases.	(1)
Department of Morbid Anatomy and Histology	
Assistant Lecturer (Griffiths)	(1)
Gull Student.	(1)
Demonstrators.	(1)
Department of Clinical Pathology.	
Assistant to Director.	(1)
Assistant Clinical Pathologists.	(3)
Department of Clinical Pathology	
Assistant Lecturer.	(1)
Demonstrators.	(2)
Chemistry Department	
Assistant Lecturer	(1)
Demonstrators.	(2)
Physics Department	
Assistant Lecturer.	(2)
Demonstrator.	(1)
Biology Department	
Assistant Lecturer.	(1)
Demonstrators.	(2)
Anatomy Department	
Assistant Lecturer.	(2)
Demonstrators.	(3)
Physiology Department	
Assistant Lecturer (and Anderson Demonstrator of Clinical Chemistry).	(1)
Pharmacology	
Assistant Lecturer.	(1)

GUY'S HOSPITAL.

Applications are invited for the following posts. Duties to commence on October 1st, 1947. Applications should be lodged in the Superintendent's Office not later than June 14th :—

Assistant Director (Female), V.D. Dept.	(1)
Medical Officers (Male), V.D. Dept.	(2)
Medical Officers (Female), V.D. Dept.	(2)
Chief Clinical Assistant, Radiotherapy Dept.	(1)
Radium Registrar.	(1)
Dental Officer to Salomon's Centre.	(1)
Dental Anæsthetist to Salomon's Centre.	(1)
Orthodontic Assistants.	(3)

T. B. JOHNSTON,
Superintendent.

PASS LIST

UNIVERSITY OF LONDON.

THIRD (M.B., B.S.) EXAMINATION FOR MEDICAL DEGREES.

April, 1947.

Honours.

T. E. Oppé.

Distinguished in Medicine.

Pass.

S. Balfour-Lynn
R. L. H. Barnard
C. Bucknall
D. O. Davies
P. J. Dwyer
R. N. M. Eminson
G. M. Evans
J. J. Fingard
H. Goldschmidt
J. M. Hall
J. G. Hamilton
J. M. Holmes
S. L. O. Jackson
O. M. Jonathan
B. Kustow
H. W. G. Loudon
J. D. Oriel
K. J. Robinson
J. G. Stebbing
J. A. Turner
D. G. A. Westbury
I. Yentis

PART I.

G. L. Blewett
D. H. Crook
P. W. Edward
C. A. Higgins
W. E. McBean
J. B. Morrison
J. A. R. Parker
R. C. Ponder
W. J. St. E-G. Rhys
J. Southgate
A. B. Wayte

PART II.

R. H. Browning
M. B. Conran
R. C. Hallam, B.Sc.
E. L. W. Leiser
H. B. F. Ordish
J. A. R. Parker
E. Robinson
D. J. Sheerboom

PART III.

J. H. Apted
J. H. Baylis
D. H. Crook
W. M. Dixon
R. L. Edwards
D. H. Forsdick
A. J. Heber
A. J. I. Kelynack
M. J. May
J. B. Morrison
T. W. Renton
P. Sattin
B. J. Stephens
P. J. F. Walsh
J. L. Warren
R. D. Willcock
P. Wilson

UNIVERSITY OF LONDON.

DIPLOMA IN PUBLIC HEALTH.

March, 1947.

W. E. Greenwood
E. R. Hodgson Todd
K. R. D. Porter
R. Tilley
R. West

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

PRIMARY EXAMINATION.

Additional.

L. R. McLaren
D. T. H. Paine
P. A. L. Roberts
M. N. Teubes
D. J. Tibbs
R. N. Ticehurst
J. D. Trethowan

BLUES' COMMITTEE.

At a recent meeting of the Blues' Committee, the following awards were made:—

RUGBY FOOTBALL CLUB.

Full Blues	*Half Blues*
H. Brunow	B. Cole
B. Ecksteen	A. A. Craigen
M. Hatton	P. Harratt
A. J. de Villiers	K. R. Helser
	D. N. H. Owen
	D. F. Potter
	N. Wolfsohn

ASSOCIATION FOOTBALL CLUB.

Full Blues	*Half Blues*
J. C. Leckie	P. N. Head
E. N. Newton	N. L. Lewis
	D. G. Matthews
	D. E. Sturdy
	P. A. Swift
	A. H. Whitaker

HOCKEY CLUB.

Full Blues	*Half Blues*
J. B. Harris	G. H. Danford
I. Kelsey Fry	E. A. Murray
W. Vans Agnew	F. H. Walker

BOAT CLUB.

Full Blues	*Half Blues*
F. de Hamel	J. G. Hunt
R. Shotts	I. H. Maine
	E. F. Soothill
	P. W. Tatford

RIFLE CLUB.

Half Blues

D. J. Cliff
J. D. Morris
B. L. Whitaker

FENCING CLUB.

Full Blues	*Half Blues*
O. F. Conram	J. M. Holden
N. H. Porter	I. A. W. Scott

BOXING CLUB.

Full Blues	*Half Blues*
A. E. McLauchlan	A. N. DuPlessis
M. Mason	F. Ellis
R. D. Walsh	N. Sherran

SQUASH CLUB.

Full Blue	*Half Blues*
L. Jacobs	H. Gillett
	C. J. G. Menzies

ERIC W. GRAHAM,
Hon. Sec. Blues Committee.

PAPERS BY GUY'S MEN

Dowling, G. B. Dermatology. *Brit. Enc. Med. Pract.* (Butterworth), *Medical Progress*, 1947, p. 45.

Clarkson, Patrick, and Another. Modern Plastic Surgery. *Ibid.*, 113.

Blockley, C. H. A Penicillin-Styptic for Dental Work. *Brit. Dent. J.*, 1947, **82**, 213.

Campbell, A. M. G., and Others. Disease of the Nervous System occurring among research workers on Swaback in Lambs. *Brain*, 1947, **70**, 50.

Doherty, W. D. Prostatic Obstruction. *Gen. Pract., Australia and New Zealand*, 1947, **18**, 29.

Ellis, R. W. B. Height and Weight in Relation to Onset of Puberty in Boys. *Arch. Dis. Childh.*, 1947, **21**, 181.

Ellis, G. G. Exposure of the Pulp due to Pressure from an Impacted Lower Third Molar. *Brit. Dent. J.*, 1947, **82**, 214.

Grasby, E. D. Y. Combined anterior pituitary necrosis and symmetrical cortical necrosis of the Kidneys following accidental hæmorrhage. *J. Obst. and Gyn. Brit. Emp.*, 1947, **54**, 203.

Reading, P. Vertigo. *Gen. Pract., Australia and New Zealand*, 1947, **18**, 29.

Reading, P. Zygomatic mastoiditis. *Lancet*, 1947, i, 702.

Ryle, J. A., and Others. Studies in occupational morbidity. *Brit. J. Indust. Dis.*, 1947, **4**, 56.

Taylor, Florence. Learning by seeing: 6. The Nervous System. *Nursing Times*, 1947, **43**, 277, 307, 325, 344.

BIRTHS

FORREST.—On May 17th, 1947, at 12, Avenue Road, N.W.8, to Irene (née Leanse), wife of J. O. Forrest, L.D.S., R.C.S.—a second son (Jeffrey Allan).

MANN.—On May 19th, at Guy's Hospital, to Gwendolen (née Mucklow), wife of Dr. W. N. Mann—a son.

DEATHS

COOPER.—On May 21st, 1947, at 15, Kingsdowne Road, Surbiton, peacefully, Harry Cooper, M.D.

HOPKINS.—On May 16th, 1947, Sir Frederick Gowland Hopkins, O.M., D.Sc., F.R.C.P., 71, Grange Road, Cambridge.

LEADER.—On April 28th, 1947, Harold Leader, M.B., of Chorley Drive, Fulwood, Sheffield.

Eds. {D.H.F. H.A.R.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LXI. *No.* 1537 21*st June* 1947 *Ninepence*

PASSIM

GUY'S men who have not seen their hospital for several years and who learn of some of the changes that it has undergone, both by design and by accident, through the medium of the *Gazette* or by a chance encounter with a colleague, will doubtless be interested to learn of some of the more recent events that have either occurred or are actually taking place at the present time. It is therefore intended to devote this Passim to a kind of bulletin for Guy's men and women who are away from their London Bridge home.

Some years ago the forecourt of the hospital was flanked on one side by the Superintendent's house and the Counting house, and on the other by the chapel and the matron's house. This worthy symmetry, it would seem, appeared to displease certain mid-European airmen who promptly proceeded to render homeless, with a number of ill-placed explosives, both the superintendent and those who count gold. Since that time the hospital has presented a rather lop-sided appearance to the visiting eye and, while affording the matron and chaplain a broader view of the surrounding squalor, this altered design is, to say the least, displeasing.

To-day, however, reconstruction is under weigh, for the foundations of a future building are to be seen in the process of being built on this waste-land which, for so long, has resembled a somewhat disorderly Stonehenge. They are the foundations of a hut which will serve as an extra ward until the new and even more wonderful Guy's is constructed.

Wards in the surgical block which, not so very long ago, looked almost beyond hope of redecoration, are now newly equipped and in use again, the number of hospital beds consequently mounting.

Work on the roof of Hunt's House (the pursuance of which is indicated by the fact that a bucket on the end of a rope is, from time to time, seen to travel at great speed up and down the side of the scaffolding which, for so long, has adorned the walls of this sadly designed building) is, we are sure, progressing favourably, albeit invisibly, in the reconstruction of the X-ray Therapy Department.

Mention has already been made in a previous issue of the repainting of the colonnade and college, and now the new Pathology block adjoining the Medical School is being dressed a delicate, if somewhat nauseating, shade of green. The gates and railings at the main entrance of the hospital are fast glorying in a new coat of black paint and the dust bowl which constituted the Park is already largely returfed and presents itself as such green pastures that we confidently await the delivery of a flock of sheep to graze in the shadows of Shepherd's House. The Belladonna bed in front of the Nurses' Home is still bare, except for some broken paving-stones, but daily

Miss Addiscott may be seen viewing this plot with grim, growing determination. Thus one waits, expectantly, to see what next spring will yield; perhaps it will be white poppies to help take the edge off State control.

THE Pavy Gymnasium at the college is soon to be opened as a cafeteria and thus provide one attempt to solve the present feeding problem. A meeting of the Catering Committee was held on June 9th and our readers, especially those at the hospital now, will be pleased to learn that a thorough investigation of the catering is to be carried out, so that many of the existing complaints may be remedied.

Furthermore, it was decided that meetings of the committee would be held at regular monthly intervals until further notice.

WE are pleased to welcome to the hospital Professor A. McGehee Harvey, M.D., who has come over for a short stay from the Johns Hopkins Foundation, Baltimore. We are already enjoying his teaching and his interest in Guy's, and are glad to learn that he has been elected an Honorary Associated Consulting Physician to the hospital. His colleague, the eminent Dr. Blalock, is to visit us later in the year.

ON Monday, June 9th, Mr. T. B. Layton conducted his last round at Guy's, thus ending a long period of faithful service on the hospital staff. There must be very few Guy's men who do not know Mr. Layton and, in wishing him a long and happy retirement, we bid an affectionate "Au revoir" to one of Guy's best known personalities.

THE job of a "hospital artist" which entails, for example, attending surgical operations to draw illustrations, although not a unique one, is not an occupation that is commonly undertaken, and we congratulate Miss Sylvia Treadgold, of the Photographic Department, who has recently been appointed Medical Illustrator to the hospital. The appointment is a new one to Guy's and we hope that her work will prove as interesting and enjoyable to her as it will useful to teachers and students.

ON behalf of our readers we offer our congratulations to Dr. Norwood East on the Knighthood conferred upon him in the recent Honours List.

IT is with much regret that we have to announce the death of Miss Nellie Martin, the porteress, on June 8th. Miss Martin who was known to many Guy's people, was a valued servant of the hospital for the past twenty years. We extend our sympathy to her relatives in their bereavement.

Obituary

LOUIS LEIPOLDT

LOUIS LEIPOLDT has died. We who were his contemporaries will always remember him as an outstanding person: he had a better brain than the rest and he spread his activities over many fields. He found it easy to learn his medicine and his surgery, and he became an F.R.C.S. but found it irksome to do his tasks as a dresser; and in those days dressers spent (I think wasted) many hours doing dressings: he was untidy, unconventional

and contradictory, but independent, imaginative and humorous. I don't remember him ever being any good at games, but early in his Guy's days he showed his journalistic ability and he became Editor of the *Guy's Gazette* in 1906–1907. No one who knew him would ever have pictured this original as likely to be an orthodox consultant or a family doctor, though he had the knowledge and the intuition to be the former, and the humanity and simplicity to be the latter. He was bound to be a success : and a success in many careers he was—as a journalist, as a pædiatrician, as a scientist, as a school inspector, as a poet, and even as an enthusiastic authority on food and drink. It was a proof of his genius that he adjusted himself so well to life : he never had the ordinary schooling that knocks the corners off, and teaches a man to mix easily with others and so conform comfortably to the conventions and the superficialities of the general pattern : he was by nature contradictory and rebellious ; the results of his upbringing were obvious ; the qualities of his mind and character were patent enough, but nevertheless he was popular as a student : and being full of brains and full enough of ambition he made a success of his life and he made a very big mark in South Africa where everybody knew him or knew of him. Guy's at that period was much enriched by the presence of this unusual, humorous, puckish, kindly free lance in thought : and we contemporaries can be very grateful to him for his stimulating and thought-provoking influence.

C. H. R.

Heart Disease and Pregnancy

A Lecture delivered at Guy's Hospital by

MAURICE CAMPBELL, O.B.E., M.D., F.R.C.P., on January 10th, 1947.*

(*Physician and Physician i/c Cardiac Department, Guy's Hospital.*)

GENTLEMEN,—Yesterday I saw a young woman, recently married, who had been to her doctor about some transient symptoms, and had been told that under no conditions was she to have any children ; she was naturally very distressed. It shows how little is still understood about the subject because in actual fact it was difficult to make sure that she had slight mitral stenosis. The electrocardiogram was normal, the size and shape of the heart on X-ray inspection were normal, but after exercise a short diastolic murmur could be heard. This patient runs hardly any more risk than any other woman during pregnancy, and the advice given was wrong.

A short time ago I saw a lady, aged 36, who had been married ten years. Doctors had frequently told her that she was not to have children, or they could not make up their minds on the question, and a decision had been put off. Finally she had taken the matter into her own hands and she only came to see me when pregnancy was five months established. Although her heart was worse, and there was some extra risk, I do not think her decision was unreasonable. But the fact that her doctors did not make up their minds means that she is having her first baby at 36 instead of at 26, with the drawbacks attending the later age, and that unless she had had the courage to act on her own she would still be waiting for a decision.

*Based on a Lecture given at the Royal College of Obstetricians and Gynæcologists in November, 1946.

Those two patients emphasise the problem and show that there are still difficulties on the part of many doctors. I think there is much too great anxiety on the subject, and I want to try to give you the conditions under which you can make up your minds reasonably and feel that you know what the outlook is.

There are really two separate problems. The first concerns the immediate risk of pregnancy at the time, and the second its effect on the heart in the future: will the patient be worse off than if there had been no pregnancy? The second question is the more difficult, and I cannot give you an entirely optimistic answer. There are risks in that direction, and it is found that a certain number of patients date their set-back to the period of one of their pregnancies. To the first question most teaching takes far too pessimistic an attitude, and one can justifiably take a much more optimistic view. I think I can give you fairly precise answers as to what the risks are in the different types of cases.

In my view it is your business to put the risks before the patient, but it is not your business to decide what the patients do with their lives. The extra risk may be so great, of course, that no reasonable person would allow it, and in such a case you may give the final decision as well as the facts. But if the risks are smaller than that it seems quite wrong to me for the doctor to decide, and equally wrong for the husband to decide (naturally he is unwilling to expose his wife to any unnecessary risk), but it is her affair to decide, and she should have the facts to make her decision.

THE RISK OF HEART FAILURE.

On this first question of danger I think the point to realise is that there is only one substantial risk—heart failure. What you are really trying to assess is whether heart failure will arise during pregnancy or soon after as a result of it. The main signs which will help you to diagnose that are, of course, the signs of congestive failure, because it will nearly always be right-sided failure—œdema of the ankles, enlargement of the liver, and crepitations at the base of the lungs. There are special difficulties about these points in pregnancy because after the sixth or seventh month some dyspnœa is inevitable in most pregnant women, and therefore you need experience to know how much can be put down to the pregnancy and how much is more than would be reasonably expected and is an indication that the heart is getting involved.

The same applies to some extent to œdema of the ankles because after the same period a large number of patients during pregnancy will have œdema, particularly if they are rather fat or have anæmia, and therefore you may think failure is present whereas it is really part of the pregnancy. Again you will need experience as to how much œdema can be reasonably expected under these conditions without having to add something from the heart point of view.

Enlargement of the liver and crepitations at the base of the lungs are more decisive signs, though if the patient has been told to take a good deal of extra rest a few crepitations at the base of the lung when she first takes a deep breath may not be significant. But crepitations that remain after taking a few deep breaths are generally significant of cardiac failure and do give you your first warning sign.

Another risk is that the patient may develop infective endocarditis. This is a small but inevitable risk that cannot be foreseen, though much can be done to guard against it by adequate attention to any source of sepsis, especially the teeth. Since the introduction of penicillin it is less serious than it was as it can now be cured successfully, even when occurring during pregnancy. Early diagnosis is of vital importance to prevent irreversible damage to the heart.

You will find later when I go into more details about the estimate of the risk in different types of patients that I am laying great stress on the size of the heart. According to older views the heart was enlarged during pregnancy; that is incorrect, but it is often difficult to decide the exact size of the heart because, after the sixth or seventh month, as the diaphragm rises, the apex beat then moves out a little to the left, so that there is a more horizontal heart, which may make one think that there is some enlargement when really there is none. This is a point to be guarded against.

When you get a patient with heart disease, the two outstanding questions before you are: Is there anything in the story that makes me think failure is imminent or liable to develop as an extra risk; and in assessing risk, what is the size of the heart? If you have doubt in this direction radiology should be used, as it can give you a precise and accurate answer, but I am not suggesting that it is needed in most cases: you ought to be able to decide, unless the patient is obese, with reasonable accuracy.

There are many other signs that may be produced by heart disease or by other causes, such as palpitation and præcordial pain, and I think you can neglect them except for treating them symptomatically. Præcordial pain is a sign of fatigue or anxiety, and this is as likely to be relieved by your decision as made worse, and therefore should be neglected entirely. True anginal pain is very uncommon in pregnancy, and therefore you must be very sure that any pain complained of is of that type before you attach significance to it.

The sensation of palpitation is, of course, extremely common during pregnancy, particularly in the later stages, and is entirely without significance; even if the palpitation is due to extrasystoles or paroxysmal tachycardia, it is still without significance. Paroxysmal tachycardia is far more common in pregnancy than is generally recognised; people are so accustomed to the patient complaining of palpitation that they do not make further inquiries as to what variety of palpitation it is. Even where there are extrasystoles or paroxysmal tachycardia the prognosis should be discussed entirely on the size of the heart and the question of failure, and these other symptoms may be neglected.

TYPES OF HEART DISEASE FOUND.

The next big question is: Who are the sort of patients with heart disease who come before you to raise this problem? It is very unlike the experience of most cardiac cases. Coronary disease is probably the commonest cause of heart disease generally, but it is almost unknown with pregnancy. I do not think I have ever seen a patient with angina become pregnant, and Bramwell in his book, which deals with the largest number of cases reported in this country, says that he has seen no instance of it. Therefore coronary heart disease needs very little attention. This is not surprising really because coronary disease is uncommon under 40—particularly in women—and therefore one would not expect to find it with pregnancy.

High blood pressure is the second commonest cause of heart disease as a whole, and that does come in in connection with pregnancy, though not to anything like the extent you might expect. In Bramwell's series of cases it was responsible for 3 per cent. of the patients, excluding those where the high blood pressure was the result of that pregnancy and where the patient had eclampsia at a late stage : that is a separate problem with which I am not dealing. The patients who have a high blood pressure at an early stage of their pregnancy form a relatively small proportion. They are rather an anxious group, because not only is there the ordinary problem as to whether they are made worse by pregnancy, but also whether eclampsia is a greater risk in these patients. I think you can decide it mainly from the size of the heart. A patient with not much cardiac enlargement, unless the blood pressure is very high, is unlikely to be affected or to run more risk than someone else. In the rare case where the heart is much enlarged, pregnancy is a greatly increased risk, and the question of its termination or of its being forbidden may have to be considered. If you get high blood pressure in a young patient without any obvious reason, do not forget that it may be due to coarctation of the aorta rather than to essential hypertension or nephritis.

The third commonest group of heart disease in ordinary practice is the rheumatic one. It is a long way down below the first and second groups, but in hospital you see an undue proportion of the rheumatic cases and a much smaller proportion of the coronary and hypertensive groups which are responsible for probably nine-tenths of all heart disease. On the other hand, from this point of view the rheumatic group is by far the most important, and 90 per cent. of the patients who consult you about the question of pregnancy and heart disease will be rheumatic, and the biggest group among the remainder the congenital ones. I shall return to this.

Next I want to mention the thyrotoxic group. These cases can be very alarming and may cause anxiety, but, on the whole, the fact that they can be treated surgically really gives you the answer. There is a real association between thyrotoxicosis and lack of children, and you do not see nearly as much thyrotoxicosis among those who have children, so that on general grounds it is undesirable that pregnancy should be stopped in these cases.

If the patient has slight hyperthyroidism with no particular cardiac symptoms it can be neglected, and there is a greater chance that the patient will be improved by pregnancy than harmed by it. If you have a more severe case, with the basal metabolism increased 40 to 50 per cent., with developing cardiac symptoms, there is no real reason why surgical treatment should not be carried out during pregnancy or, better still, if your advice is sought early enough, before it : the patient can be treated and cured first, and will then be normal from this point of view.

The next group to discuss is those with syphilitic heart disease, but this, like the coronary group, is almost non-existent among the people of whom we are speaking. On the average it takes twenty years for syphilitic heart disease to develop after the primary infection, so that most patients are too old for pregnancy, and I cannot remember seeing an instance.

The mere occurrence of a positive Wassermann, of course, is without significance from this point of view, though important from many others. Many people think that a patient who has aortic incompetence is probably syphilitic, just as they think that in all rheumatic cases mitral stenosis is

present. That is not true clinically, though it may be true that the pathologist can find some degree of rheumatic mitral disease. The commonest cause of pure aortic incompetence is rheumatism, not syphilis. Many of the cases of aortic incompetence, therefore, are rheumatic.

CONGENITAL HEART DISEASE.

The last group consists of congenital heart disease, and these cases are important in connection with pregnancy. You will see a good many instances where this problem is raised. On the whole, the patients with gross cyanosis do not become pregnant. Relatively small numbers of them get married, though I remember a complete cripple, with a heart almost in failure, who had spent the greater part of the last five years in bed, getting married during that period and starting a pregnancy. Therefore severe congenital disease will not always rule out the possibility, but, on the whole, the grosser degrees of it make pregnancy unlikely, so that the problem will generally come to you in the person of someone who thinks herself fairly fit and has little or no cyanosis.

Septal defect is probably the commonest abnormality. By itself it is a very harmless defect, which can be neglected. On the whole it seems to be associated with a good prognosis, and should not be allowed to affect the patient in any way. Patent ductus arteriosus, which is easily recognisable on the long continued systolic and diastolic murmur just to the left of the pulmonary area, is so distinctive that you can be sure of the diagnosis in many cases if you have heard a single instance of it. It does not tend to be associated with much cardiac enlargement, and on the whole these patients do very well.

Coarctation of the aorta is not rare, and one particular patient illustrates what I said about the importance of remembering this when you get a patient with high blood pressure. In 1932 I saw this lady after her pregnancy. I found her blood pressure to be 210/110, and although she had got through that pregnancy all right, I strongly advised her against another, because with such a pressure when only 25, it was likely to increase to a dangerous extent as the years went on. Three years later, however, she turned up again with a second pregnancy, and either because I had learned more about coarctation or because her collateral circulation had developed during that time I was able to make a correct diagnosis. There was quite a good collateral circulation showing round the scapula, and the blood pressure was at about the same level as before. She got through her pregnancy perfectly well. I heard no more about her until during the war. She had left London, but having become pregnant a third time, and now being 37, she came back to Guy's for her confinement. Her blood pressure was still the same, her arteries had thickened, she had a most striking collateral circulation; but in spite of everything she got through her third pregnancy quite satisfactorily. It was a risk in which I certainly should not have encouraged her; but it is of interest to bring it before you as showing what gross changes may be compatible with a successful pregnancy. On the whole the outlook in the congenital cases is good, and the grosser degrees of congenital heart disease will not often come before you.

RHEUMATIC HEART DISEASE.

I can return now to the main rheumatic group and try to assess their risk. I do not think it makes very much difference what the form of valvular disease

is. The view has been put forward that aortic incompetence is more dangerous than mitral stenosis and that the combined lesion is worse than either. Probably the latter may be true statistically, because the combined lesion may go with the larger heart, but I think you can neglect the actual type of valve lesion and consider them all together and go entirely on the size of the heart.

One of the last researches of Dr. Hunt before his death was a complete follow-up of about 150 patients with rheumatic heart disease in pregnancy who had been attending here on and off for a good many years. When he died he had fairly complete notes of the results, and I published a paper in the *Guy's Hospital Reports* (1926) on the results of these findings. The patients have been divided into three groups regardless of their valvular disease. Actually some valvular diseases were separated, but the results were so much the same that I give you them all together.

Those who had mitral stenosis or aortic incompetence with hearts substantially of normal size had practically no difficulties during confinement and did well subsequently. In the second group of those with moderate enlargement of the heart, there was an increased risk. The actual number of fatalities was nearly up to 10 per cent—I will show you why that figure is an artificial one in a moment—but one must admit that there is an extra risk, and I think, on the whole, it is about eight to ten times the normal risk of pregnancy. That may sound high, but the normal risk of pregnancy is so low and is being further reduced that even eight to ten times that is still small. I think that in all these patients where there is a major enlargement of the heart you will have no right to let the patient undertake pregnancy without the realization that they have some increased risk, but this is sufficiently small for it to be taken if the patient is anxious to have a child.

The third group consists of those where there have been any signs of failure already or where there is auricular fibrillation. There the risks are so great that the patient passes into the last category in which, instead of giving her advice, you forbid pregnancy or terminate it if it has commenced and is still at a reasonable stage for doing so. On the whole the mortality is high, somewhere in the neighbourhood of 30 per cent, and most of the patients are made worse. A point that is of value to you if the patient is very reluctant to accept your advice is that in a large number of cases—nearly up to half—there is not a living child as the result of the pregnancy. Therefore where there is failure or auricular fibrillation you can regard this as an absolute bar.

The next point I want to take is that rather alarming figure of 10 per cent mortality and show you how that is made up of a small group of bad results and a much larger group with a reasonably small risk. You will find the most detailed figures on this question in a book by Bramwell and Longson (1938), entitled *Heart Disease in Pregnancy*. Their conclusions are very much the same as those I am giving you to-day, though they so not lay quite as much stress on the differentiation of the rheumatic cases according to the size of the heart. They describe the details of 350 cases : there were 14 deaths in one group of 25, and only 11 deaths in the remaining 325. Those 25 with the 14 deaths were patients who had not been under the hospital's ante-natal supervision ; they were admitted as urgencies, in other words, some were admitted moribund or with severe failure, and they included a large proportion who either should have been advised against pregnancy or had their pregnancy terminated at an early stage or had had no adequate supervision and treatment during pregnancy. The 11 deaths among the

325 other cases gives you the real factor of risk, because these were patients who had had ante-natal supervision and treatment where necessary. It shows you that there is a reasonable chance of a satisfactory result with the great majority. It is also very encouraging that these figures should be so extraordinarily different, as showing the advantages of proper ante-natal supervision, and how much can be done by adequate rest and treatment of the patient during pregnancy to get satisfactory results.

THE PROGRESS AFTER PREGNANCY.

At this stage I should like to say a little more about the second question: How far is the patient likely to be made worse by pregnancy? It is more difficult to give a precise answer to this question. You will find in any large group of patients with fibrillation or with mitral stenosis that some of them attribute the onset of their fibrillation or deterioration in their condition to a particular pregnancy. Against that you have to set the fact that mitral stenosis is a relatively serious disease, and that, although patients do sometimes live to old age, it is tending to get worse on its own.

In a careful review by Gilchrist and Murray-Lyon (1933) of the age at death of patients with rheumatic heart disease, it is stated that the average age is about 40, so that if you take the average age of your patients with pregnancy as being about 30 you will see that they have not anything like the normal expectation of life, and, quite apart from pregnancy, there is some liability for their condition to get worse. These figures support the rather optimistic view I gave you about the effect of pregnancy, because the average age at death of those who had had children and those who had not was just the same in this series, so that there was nothing to suggest that pregnancy had a particularly deleterious effect. But you must recognise that there is an added risk, and that some patients will get worse after it; both must be considered.

This brings one to the question of future advice. So far I have simply spoken of the whole question as one of the particular pregnancy. But when you are dealing with a patient with rheumatic heart disease, unless she is in the favourable group with a heart that is hardly enlarged, you want to see that the pregnancies are spaced out at reasonably long intervals and that the total number is limited.

A point sometimes forgotten is that you have to take a long view, not merely of the risk of the pregnancy, but of the work the woman will have to do during the following ten years looking after her children. A patient with mitral stenosis and enlargement of the heart will not improve, and in ten years' time will generally need to have more rest than now, and with a large and growing family she is unlikely to get the rest she needs. In that sense children should be limited and well spaced, even more than from the point of view of the actual risk of the pregnancy.

SOME PRACTICAL CONSIDERATIONS.

Finally, there are certain special points I want to discuss about these patients. Supposing she has not come to you to get advice before pregnancy, but is already pregnant. Up to three months, in the group with failure and fibrillation, pregnancy should always be terminated. After three months—perhaps some people would say after four months, but we will leave it at three for safety—the risk of terminating the pregnancy is really greater than the risk of allowing it to continue. Therefore you are presented with a *fait accompli*

and you cannot do much about it except give the patient very careful treatment. This will equally apply to the patient who develops failure for the first time in the sixth or seventh month, and here, if the patient has complete rest and adequate treatment with digitalis, she will often make such good recovery from her failure that she will finish the pregnancy satisfactorily and be free from signs of failure afterwards and almost as well as before. But such a patient will have given you a warning for the future, and you will know that that is the last pregnancy to be allowed, and that she must be told that the risk would be so serious that any future pregnancy must be forbidden.

Therefore the treatment of failure in the patients in whom it develops at a later stage and in those who have not given you an opportunity of advising them early enough is a most important point, and the response is good. You will often be asked whether premature induction of labour is desirable in these patients. My answer is that it would be very desirable if the obstetricians knew how to produce it with certainty, but the attempt may be disappointing, and very often not successful. Although you will always be pleased if the child is born sooner rather than later, I think on the whole it is best to leave that alone and let the birth come naturally at the time that it does start. Obstetricians would agree that they cannot really be very certain that the special measures are going to succeed, and where they do not succeed, the difficulties and discomforts of the patient are increased.

There is no difference of opinion about the second stage of labour. This should be as short as possible and will generally entail the use of forceps.

Cæsarean section.—One of the questions that frequently arises is whether Cæsarean section or natural labour is indicated. There is some difference of opinion: Cæsarean section is more common, on the whole, in America, and in certain hands in England; but I think the best opinion is that it is not specifically indicated because a patient has heart disease. If there is any reason whatever for anticipating difficulty in labour, and sometimes in the ordinary case, you will weigh the risk and consider whether the procedure is justifiable. I think there it has an advantage in some cardiac cases, but it is not a much smaller strain on the heart than normal labour, particularly if normal labour can be shortened to the greatest possible extent. In coarctation of the aorta, for example, it is specially indicated. It has one practical advantage, that if the child is delivered by Cæsarean section, sterilization is possible at the same time, and this is a help when you have advised that there shall be no future pregnancy. It is true that there are other methods of avoiding children in the future, but in my experience birth control methods are ineffective in patients with mitral stenosis, whatever they may be in others. Therefore I prefer sterilization where I think further pregnancy is a serious risk. But I do not think obstetricians will allow this to influence them in deciding between Cæsarean section and normal labour; they will say that sterilization should be done later if needed.

Anæsthetics.—The last general question concerns anæsthesia. The anæsthetist matters very much more than the anæsthetic, and this applies to many branches of medicine. It is much better that the man who has particular experience should use the method with which he is familiar and successful rather than try something with which he is not so familiar because he is dealing with a case of heart disease. There are two answers that you want to give the anæsthetist as to your aim. The first, and much the more important, is the avoidance of any anoxæmia; this is the real strain on the

heart in these cases, and so an adequate oxygen supply should be ensured during the whole anæsthetic: the second is that the whole process should be as short as possible. Within these limits the anæsthetist may use the method which he is familiar with and likes.

Rest.—You will need to advise extra rest in a large number of your patients. It is useful to tell the patient that heart disease throws extra work on her heart, and that if she wants to do well and reduce her risks to the minimum, she must agree to extra rest throughout the period of her pregnancy. It is difficult to give you figures, because the amount of extra rest that normal patients need during pregnancy is very variable, and must be gauged by experience and by their progress; but most patients with heart disease of any significance should aim at a 12-hour night and 2 hours' extra rest during the day: that allows a large margin of time in which to do things. In the later stages of pregnancy it may be necessary to increase on these resting figures considerably, but you should regard them as the minimum for those with any significant degree of enlargement of the heart.

The last point I should like to emphasize is that many people think that within a week or so of the confinement the risks are over. The six weeks after confinement are in fact an almost more dangerous time from the heart point of view than any time during the preceding period. Just as much care should be taken during this time as before. In view of the inevitable extra work which the patient will have to face in many directions for a year or more afterwards, it is very important to see that the extra rest is maintained during that critical period and to a lesser extent during the year that follows.

Honours and Awards

BY A VILLAGE DOCTOR.

THERE are various degrees of honours and awards, but I have never been able to understand how the Powers That Be assess the value of services rendered so that they may decide what particular honour to bestow in any specific case.

I am not thinking so much of academic honours such as university degrees, some of which are conferred for distinction in scholarship in one faculty or another and some for outstanding services to the country. I once had a pretty near shave of receiving an LL.D., which would have come my way had I succeeded to a particular job at the right time. As it was, a predecessor of mine was the lucky man—not because either of us were distinguished by scholarship, but because the position was an honourable one and a particular conference happened to be held within the walls of a famous university.

What I am thinking of particularly are the honours awarded by His Majesty The King on the recommendation of his Ministers. Let me say at once that I am not thinking of decorations awarded for political services; for in my estimation and the estimation of many others, these are of no intrinsic value. Nor am I thinking of awards for services in the field, of which the Victoria Cross is pre-eminent. All the same I do not think there can be any doubt that they whose trade it is to destroy life invariably receive higher awards, both honorific and monetary, than those whose mission it is to save it. Why?

For instance, how many lives have been saved by, say, insulin, and how

many people are living happy and useful lives because of this discovery, who would certainly have been doomed to die without it?

Moreover the total is rising year by year and must by now have amounted to many hundreds of thousands. For his discovery, Banting received a simple Knighthood—but not until some years afterwards.

Take penicillin for example. Ever since it was made available, it has been saving lives and suffering and will continue to do so for untold years to come. Would it be wrong to say that in another ten or twenty years it may have saved as many lives as were destroyed in battle during the two Great Wars? For its discovery, Fleming received a Knighthood, as did his coadjutor Florey.

Lord Lister is the only man I can think of who received a peerage because of his discovery of a method which would relieve human suffering and save human lives. I can think of other medical peers, of course, but most, if not all of them, owe their elevation to political or personal services, rather than the brilliance of their work in the cause of suffering humanity.

At what value, I wonder, would discovery of the cause and cure of cancer be assessed? Perhaps the usual knighthood—although surely it would merit a Dukedom at the very least.

It has always been a puzzle to me how these things are assessed, even though at one time it was part of my job on a humbler plane, to have to make recommendations.

Can somebody tell us how it is done?

Sport

CRICKET RESULTS

GUY'S *v.* PRIVATE BANKS.
(May 3rd, 1947)

Result: Lost by 44 runs.
Private Banks: 167 for 8 wkts. dec. (E. W. Graham 4 for 63).
Guy's: 123 for 10 wkts.

GUY'S *v.* WANDERERS.
(May 7th, 1947)

Result: Lost by 7 wkts.
Guy's: 125 for 10 wkts. (J. D. Williams 42 not out; V. Ransom 6 for 49).
Wanderers: 126 for 3 wkts. (Avery 60 not out).

GUY'S *v.* CAMBRIAN C.C.
(May 10th, 1947)

Result: Won by 48 runs.
Guy's: 147 for 10 wkts. (Gilbert 47 not out).
Cambrian: 99 for 10 wkts. (Nicholson 4 for 14).

GUY'S *v.* ASHTEAD C.C.
(May 11th, 1947)

Result: Lost by 3 wkts.
Guy's: 181 for 9 wkts. (Harvard Davis 46; Woodford 42).
Ashtead: 184 for 7 wkts. (Woodford 2 for 11).

GUY'S *v.* THE CRICKETS
(May 17th, 1947)

Result: Won by 70 runs.
Guy's: 193 for 7 wkts. dec. (Holmes 77, Platt 34).
Crickets: 123 for 10 wkts. (Woodford 5 for 39).

GUY'S *v.* HARTSBURY CLUB.
(May 18th, 1947)

Result: Drawn.
Guy's: 171 for 6 wkts. dec. (J. D. Williams 40, Scott 32 not out).
Hartsbury: 81 for 8 wkts. (Woodford 5 for 24)

GUY'S *v.* THE STOICS.
(May 21st, 1947)

Result: Lost by 7 wkts.
Guy's: 171 for 10 wkts. (Billingham 38, Holmes 34, O'Driscoll 33).
Stoics: 177 for 3 wkts. (Davies 91 not out).

GUY'S *v.* CROFTEN PARK.
(*Played at H.O.P. on Whit Monday and won by* 1 *wicket.*)

This game between Guy's and our co-tenants of Honor Oak Park proved the most exciting game so far this season. Guy's, having lost the tosstook the field,

and their attack was opened by O'Driscoll with rapid deliveries and Woodford with off-spinners.

Success was soon forthcoming when, with only 4 runs scored, O'Driscoll made his man play outside one; this was soon followed by a similar fall of wicket while Woodford, not to be outdone, quickly sent back two more (36 for 4). Graham relieved O'Driscoll and with his first ball saw his victim caught by the wicket-keeper, in acrobatic style, about a yard in front of the batting crease. By lunch time the score read 76 for 6 wickets.

Afterwards, largely due to Denery, Crofton Park restored their position somewhat and when he was bowled by a fast full toss by O'Driscoll the total was 149 of which he had scored 80.

Guy's started confidently against a moderate attack, but the opening pair were back in the pavilion very soon. Williams and Gilbert batted confidently, but the latter soon left and was followed by Platt soon afterwards. The captain enabled tea to be taken early by putting a full toss into the hands of mid-off. 45 for 6. After the refreshment things did not improve and soon the scoreboard read 65 for 8 wickets!

The tide now turned. Graham and Munro came together, and by patient labour pulled the game out of the fire. Munro set the pace in true Yorkshire style, and Graham played excellent cricket, exhibited self restraint in playing the bowling. These two were not separated until 124 was the score. Now Woodford, the last man, came to the wicket and helped Munro bring the score to 149. The latter then won the game with a confident 3. Munro, in his last appearance for Guy's, batted very well and was undefeated for 45.

Team: J. D. Williams, R. G. Nicholson, E. W. Graham, A. M. Platt, I. A. H. Munro, R. Harvard Davis, G. P. Billingham, H. R. C. O'Driscoll, P. S. Holmes, M. C. Gilbert, J. F. Woodford.

Scores: Crofton Park, 149 for 10 (Denery 80, O'Driscoll 5 for 51).

Guy's: 152 for 9 wkts. (Munro 45 not out, Graham 25).

GOLF SOCIETY

The first London University Golf League match of the year was played at Sundridge Park on Wednesday, May 28th. Our opponents were St. Bartholomew's Hospital, and the match resulted in a win for us by six matches to nil. W. Vans Agnew celebrated his recent election as Captain of the Golf Society by winning his match by the large margin of "8 and 7."

Results were:—

	Guy's		
W. Vans Agnew	8/7	.....	1
J. M. D. Grant	4/3	.....	1
D. F. Cottier	2/1	.....	1
J. K. Anderson	7/6	.....	1
D. M. Griffiths	3/1	.....	1
J. D. Crowlesmith	6/4	.....	1
			6

	Bart's	
Juckes	.....	0
Hawkes	.....	0
Graham Stewart	.....	0
Lonsdale	.....	0
Kinsinan	.....	0
Rothnie	.....	0
		0

The London University Golf Trial Match was run concurrently with this match, and of the 28 competitors members of the Guy's team gained 5 of the first 10 places.

Hospital Information, etc.

NOTICES

GUY'S HOSPITAL MEDICAL SCHOOL.

Applications are invited for the appointment of Assistant to the Director of the Department of Pædiatrics. The appointment is for two years in the first instance, to commence in September. Applicants should hold the M.D., or M.R.C.P. Salary £750–£1,000 per annum, with superannuation and family allowance. Copies of Standing Orders for the appointment are obtainable from the Dean, to whom ten copies of application with the names of three referees should be forwarded not later than 26th July, 1947.

GUY'S HOSPITAL DENTAL DEPARTMENT.

Applications are invited for the post of Dental House Surgeon—two vacancies in the Conservation Room (1 resident), one vacancy in the Children's Department, one vacancy in the Prosthetic Department—for the period July 15th to November 15th 1947; salary at the rate of £3 10s. per week. Candidates must hold a registrable dental qualification, and applications from ex-Service practitioners will be welcomed. Applications indicating appointment preferred and accompanied by copies of recent testimonials should be lodged with the Superintendent, Guy's Hospital, S.E.1, on or before Saturday, June 28th, 1947.

GUY'S HOSPITAL COLLEGE CATERING COMPANY.

A meeting of Directors was held in the Medical School Committee Room on June 9th last. There were present: Dr. Boland (who was elected chairman), Professor Johnston, Mr. T. J. Evans, Dr. Rowlatt (President of the Residants), Mr. T. L. Lewis (Students' Club Secretary), Mr.

J. H. E. Winston (Secretary), Mr. R. A. Keeble-Elliott (Students' Club representative of resident students), and Mr. T. B. Brewin (Students' Club representative of non-resident students).

A number of criticisms and suggestions regarding present feeding arrangements in the College were put forward and discussed at some length by the committee. It was proposed by the Chairman and unanimously agreed by the committee that further meetings should be held at regular monthly intervals until further notice. It is thus hoped to keep all matters constantly under review and to adjust present and future arrangements as may be thought necessary.

Criticisms and suggestions are welcomed and should be addressed to the Secretary of the Students' Club.

STUDENTS' HEALTH SERVICE.

Student Out-Patients is held every Saturday at **10 a.m.** To avoid waiting, it has been decided to adopt an appointment system, and all students who wish to attend should make an appointment with the Secretary to the Health Service beforehand. (Telephone: HOP 3500, Ext. 15 or 297 on the internal system.)

DEPARTMENT OF SURGERY.

During the latter half of June there will be an exhibition in the Gordon Museum illustrating the Surgery of Bone Tumours.

On Saturday, June 28th, at 10.30 a.m., there will be a Clinico-Pathological Demonstration in the Anatomy Lecture Theatre.

On Tuesday, June 24th, at mid-day, there will be a demonstration in the series "Operative Procedures" in Theatre 2.

CLINICAL LECTURE.

Dr. J. Craft, i/c Research Department, Ministry of Pensions, Queen Mary's Hospital, Roehampton, will give a Clinical Lecture in the Anatomical Theatre on Thursday, July 10th, at 1 p.m. The subject will be "Amputations and the fitting of modern artificial limbs, with demonstrations by patients."

PASS LIST

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

L.D.S.

FIRST AND SECOND PROFESSIONAL EXAMINATION.

May, 1947.

Dental Metallurgy.

H. G. Carr
J. G. G. Dixon
G. D. Gibb
P. R. Jones
W. H. Legg
N. I. Lewis
M. J. March
F. R. C. Mathias
R. E. W. Pearce
W. C. Porter
P. Readings
W. J. A. Reed
G. S. Rose
P. J. Saville
J. J. F. Staub
C. A. P. Steele
P. A. Swift
R. L. G. Thornton
E. Tweddle
D. R. Whittington

Dental Mechanics.

A. Black
D. G. Brett
V. H. Freiberger
R. G. Fricker
D. M. Griffith
P. Griffiths
G. E. Moore
H. L. Scott
M. J. Smallcombe
W. R. Thomas
S. Torda
R. V. Warren
P. J. Wright

Anatomy and Physiology.

D. G. Brett
P. Frank
D. M. Griffith
H. C. Hole
M. J. Humphry
J. C. Leckie
A. P. Leech
J. G. Lloyd
O. D. Nazroo
M. J. Quelch
W. M. Sheeran
G. F. Thompson
H. G. S. Thomson
G. J. L. Want
R. V. Warren

SPECIAL ANATOMY AND PHYSIOLOGY

E. J. Annen
R. D. Baker
W. Finkel
P. F. Howe
B. S. Saunders
M. J. Smallcombe
P. H. Tucker
J. R. Waller
W. J. Wolfsohn
N. J. Wood
S. L. Woolgar

SOCIETY OF APOTHECARIES OF LONDON.

FINAL EXAMINATION.

April, 1947.

Midwifery.

P. S. Carton-Kelly
A. R. Ellerker

FINAL EXAMINATION.

May, 1947.

Surgery.

A. R. Ellerker
*R. D. C. Hart
K. Y. Khong
*P. Sattin

Pathology, Bacteriology and Forensic Medicine.

C. D. Bulstrode
K. Y. Khong
*P. Sattin
M. E. N. Smith

Medicine.

*P. Sattin
M. E. N. Smith
G. F. Vaughan

Midwifery.

*P. Sattin
M. E. N. Smith

* Have completed the Examination.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

F.R.C.S.

FINAL EXAMINATION.

May, 1947.

A. J. P. Graham
R. E. Horton
J. McA. McArthur

PAPERS BY GUY'S MEN

Ambache, N. The electrical activity of isolated mammalian intestines. *J. Physiol.*, 1947, **106**, 139.

Atkins, H. J. B., and Key, J. A. A case of myxomatous tumour arising in the adventitia of the left external iliac artery. *Brit. J. Surg.*, 1946–7, **34**, 426.

Dutton, F. C. Case history of Ludwig's Angina. *Brit. Dent. J.*, 1947, **82**, 229.

Hallam, J. W. Exostosis of the coronoid process of the mandible and true joint formation with Zygomatic arch. *Brit. J. Surg.*, 1946–7, **34**, 432.

Little, K. McM., and Another. Penicillin in Dental operations. A preliminary report. *Brit. Dent. J.*, 1947, **82**, 229.

CHANGE OF ADDRESS

J. W. A. Crabtree, M.B., B.Ch., 53, Lee Road, Blackheath, S.E.3. (Tel.: Lee Green 1972.)

W. M. Philip, M.R.C.P., 25, Selwyn Road, Edgbaston, Birmingham.

APPOINTMENTS

John Gordon, M.R.C.S., D.A., appointed Honorary Anæsthetist to the Kingston Victoria Hospital, Kingston-on-Thames, Surrey.

MARRIAGES

KEATES—BOWRA.—On Saturday, May 31st, 1947, at Southwark, Michael D. Keates to Mary Bowra.

BIRTHS

DAVIS.—On May 29th, 1947, to Hope and Colin Davis, 13, Glenmore Road, Salisbury—a daughter (Nicola Campbell).

DEATHS

MARTIN.—On June 8th, 1947, in Mary Ward, Nellie Martin (Porteress, 1928/1947), a loyal and valued servant of Guy's, aged 71 years.

EDS. {D.H.F. H.A.R.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

WHAT is it that determines whether or not a person has social sense? Does it come to a man with his chromosomes? Is it derived from good upbringing? Is it driven in by good schooling? Or is it derived in part from all three? It is difficult to say. Like good manners, there is marked inconsistency in its distribution. Of two blood brothers, brought up in the same home, going to the same house together at the same school, one may be gifted with them, while the other remains conspicuously without. Like good manners, too, it is based on a continuous and almost subconscious consideration for the existence of "the other fellow." But whatever the ætiology, one thing is certain of both social sense and good manners: in some people they are lamentably lacking.

Who so consistently leaves all the test tubes in the urine cupboard gummed up with gubbins? He must know as well as you and I know, that whereas it takes approximately five seconds to wash out such a tube if it is done immediately after use, and no time at all to put it in the rack, full of cold water, it takes us well-nigh five minutes with soap, wire brush, hot water and much sweat of the brow to do the same thing next day. Yet the rack is permanently full of the filthiest specimens.

Who is it who, when at the head of the queue to palpate a lump at out-patients, spends ten minutes aimlessly mucking around, while you and I patiently wait? He must know that if everyone spent ten minutes, only six people would palpate that lump in the hour, and the last three would be compelled to refrain out of compassion for the patient. But with the utmost regularity he dawdles.

Who is it who can see two poor old dears in the Park walking this way and that, obviously lost and gazing forlornly into doorways, and yet stroll by without a word of "Can I help you, Ma'am?" Who is it who takes current numbers of the journal from the library and fails to return them, who borrows books and scribbles in the margins, or who talks to his neighbour disturbing the peace not only of that gentleman but also of the other ninety and nine?

Who is it? It's the same man, mostly, who in the Navy was always saying "Well that's not *my* job," who in the Army muttered as he took the best straw and far more than his portion, "— you Charlie, but *I'm* alright," or in the R.A.F., persistently stood aside with, "After you, Claud." Yes, we know him. And there was a way of dealing with him. There is always a way of dealing with such people where men live a communal and inter-dependent existence. The treatment varied, but generally speaking, one fixed him. After fixation he often became quite a good social animal. The prospect of double fixation didn't appeal!

Here in a post-war world where people so quickly seem to have forgotten the joys of depending and being depended upon, of helping and being helped,

life is so much more an individual smash and grab raid that it is not so easy to coordinate the measures indicated by universal distaste.

But there's grass back in the Park again. Green grass to gaze upon, and it's refreshing to those who either from illness or occupation must perforce dwell in the precincts of Guy's.

Let us pledge that the first (or any subsequent) person seen cutting corners and treading the green away to bare earthy brownness again, shall be fixed—well and truly fixed.

WING Commander H. M. Stanley Turner, M.B.E., M.D., has been elected President of the Surrey Branch of the B.M.A. We feel sure that readers would like to join us in congratulating one of our most regular contributors.

The Care of the Anæsthetised Patient

A Clinical Lecture delivered by E. H. RINK, B.M., B.Ch., D.A., Honorary Anæsthetist, Guy's Hospital, at Guy's Hospital Medical School on Monday, March 10th, 1947.

GENTLEMEN,—The care of an anæsthetised patient is not a matter solely for the consideration of the anæsthetist and surgeon concerned, though naturally the major share of the responsibility devolves upon them. But the protection of the patient from injury during the eventful progress from his bed, premedicated, to the anæsthetic room, from the anæsthetic room to the operating table, from there back to bed and until he is fully conscious, should be a matter of personal concern and vigilance to every individual who has to do with him during this time. I should like you to consider the full implications of what we do when we anæsthetise a patient. We deprive him not only of his consciousness and of his perception of pain, but also—and this is a most important consideration—of his reflex defences against incidental trauma, heat and cold; and we cause a profound disarrangement of his temperature regulating mechanism. We convert him, in fact, into a very defenceless creature indeed, and therefore it behoves us to exert ourselves to the utmost to see that he comes to no harm.

The purpose of anæsthesia is to protect the patient from surgical pain and from the worst effects of surgical trauma, but there are a good many other dangers of an incidental nature from which we must also protect him. In this consideration of the defenceless animal which we have deliberately created—for his own good, though occasionally it may turn out to be for his harm—I propose to discuss three stages, namely, the stage of induction, the stage of maintenance and the stage of recovery. All of these should be important to every single person who has to deal with the patient. If any of the accidents which I am about to describe should occur, and a spectator has been standing about with his hands in his pockets thinking that it has nothing to do with him as he is neither giving the anæsthetic nor doing the operation, he must be reminded that these things have to do with anyone who is in any way concerned with the patient.

Let me begin with the stage of induction of anæsthesia. I think that the patient's anæsthesia starts from the moment at which he receives his pre-anæsthetic injection in his bed. Most of you probably think of it as beginning

in the anæsthetic room, but it actually started an hour previously when the patient was given an injection of omnopon and scopolamine. This pre-anæsthesia can be an extraordinarily pleasant experience. If during it a patient is left quietly alone he usually subsides into a happy and dreamy condition in which he is dulled of almost all apprehension. But if there are people about, talking and laughing and making a noise, this effect is not obtained; indeed, the result of lack of quiet may be rather to produce hypersensibility. The effect of scopolamine and hyoscine is generally a stimulating one during the first three quarters of an hour of its action, and it is only after this that it becomes depressant. If, during the period of stimulation, the patient is disturbed, these drugs may continue their action as stimulants, and that real depressing effect which is desired may not be obtained. The reason I am saying this is to emphasise what you must all know, that when a patient has been given his omnopon and scopolamine, he should be kept quiet, like any other patient who has been given a hypnotic, allowed to go to sleep, and moved as gently as possible.

There are other agents with more powerful effect than omnopon and scopolamine which are sometimes used for premedication. Examples of these are avertin, rectal paraldehyde and nembutal. With these more powerful agents the patient usually becomes completely unconscious and his reflexes abolished, or so far diminished as to make it dangerous to leave him unattended. In such a condition the muscles of the jaw may become relaxed sufficiently to endanger the air way, and an unattended patient in this condition may die of asphyxia. It is unlikely that a patient so pre-medicated will be unwatched while still in his bed, but I wish here to emphasise the vital importance of a watch being kept on his respiration during the difficult period of transit to the anæsthetic room.

Another point is that, however trifling and tedious the operation may appear to the onlooker, it is for the patient himself the most important of events, and he should be allowed to suppose that it is as important to those attending him as it is to himself. The patient, when he comes to the theatre, will be upset if he hears people discussing the last case or the case after next. His own case is the only one of any interest to him at that moment.

We now have the patient in the anæsthetic room, where we come to what used to be a very common difficulty, that of the patient struggling during induction. With modern methods this difficulty does not arise very often, or in a far less degree, but nevertheless, it may happen that a muscular patient will struggle violently during the induction of anæsthesia, and therefore you should have some idea of how best to control him in order to avoid injury not only to him but to yourselves.

A patient who is struggling during the second stage of anæsthesia is sub-consciously trying to get his hands up to his face in order to remove the mask. The best way to prevent him from doing this is to hold both his elbows firmly down on to the trolley or table; if, at the same time, the anæsthetist is preventing flexion of the neck, the patient will be unable to reach his face with his hands. This is the only really safe method by which to restrain violent movement of the arms; if violent restraint is applied to the wrists, a fracture of the bones of the forearm may result. Restraint of the lower half of the body is most easily obtained by the full weight of a body thrown across the patient's thighs.

Even during an apparently quiet induction the anæsthetist should never be left alone in the anæsthetic room with his patient; somebody else should always be present, partly in case it is necessary to fetch something in a hurry, and partly to maintain a most vigilant watch for any sudden movement which the patient may at any time make. It is comparatively easy for a patient to damage his hands and forearms and even his head by an unexpected movement which may cause him to impinge on one of the hard excrescences of the anæsthetic machine.

We next come to the stage when the patient, having been anæsthetised, is taken into the theatre. Here we have reached the maximum degree of the helpless state which I have mentioned. The patient has now no reflex mechanism to protect himself from trauma; he must rely for this on the vigilance and good sense of those around him. The first important consideration when the patient is brought into the theatre is to place him in the position in which he is to be operated upon.

The majority of operations are performed with the patient lying on his back, and no very great problem arises from this position; but it is important to see that the hands and arms are correctly placed. Whether the hands are to be placed flat under the buttock, or the arms are to be secured across the chest, it is important for one person to be definitely responsible for placing them there, and to make certain that they are at no time allowed to fall outwards from the table. Should they be allowed so to fall, an injury to the brachial plexus may result, and, the arms are at the same time very vulnerable to trauma.

Patients have sometimes to lie prone; this is a very trying position for the anæsthetist, as respiration is carried out at a disadvantage. In placing the patient in this position it is again important for some definite person to take charge of the patient's arms, as the underneath one in particular may easily be damaged in turning the patient over. Similarly, when patients have to lie on their side the underneath arm may be liable to trauma; I personally like best to have it flexed and the hand tucked under the pillow. Another opportunity for injury to the arm may occur when it has to be held outwards on an arm-rest for the purposes of intravenous injection or infusion during the operation. In this connection it is very important for someone to see that the rest is raised and lowered with the table. If the arm-rest is allowed to remain low when the table is raised, compression of the musculospiral nerve may result in a palsy of some weeks' or months' duration. I think I have said enough in this connection to impress upon you the vulnerability of arms in an operating theatre and the necessity for care and vigilance if serious trauma is to be avoided. Remember that accidents are most likely to occur at the end of a long afternoon when everybody is tired and becoming less attentive.

I have already mentioned that in anæsthesia you upset for the time being the patient's temperature-regulating mechanism, and convert him in some degree into a poikilo-thermic animal. Thus the operating theatre should be kept warm, from 70 to 72 degrees Fahrenheit is the ideal temperature, and the patient should be protected against draughts from open doors and windows. He should also be covered with blankets, which should be light rather than heavy. The deeper and longer the anæsthesia, the more profound will be the disturbance of temperature regulation. In this country, room temperatures higher than that of normal body temperature are never en-

countered, but as an exercise in applied physiology you may find it profitable to consider how you would deal with a patient in a theatre with a temperature of over 100 degrees.

To my mind the most anxious period of any ordinary anæsthesia is that between when the patient leaves the operating table and recovers consciousness. When the patient is on the table in the hands of the anæsthetist, everything is, or should be, there which may be needed to deal with any emergency that may arise. The table may, if necessary, be tilted in any required direction, suction is available for removing vomited material from the pharynx, oxygen cylinders and means of administering oxygen are easily to hand, as are also any necessary tracheal tubes. But once the patient has left the theatre and is on the trolley, the situation is very different. If the patient vomits and becomes obstructed, the trolley cannot be tilted, no mechanical suction apparatus is available; oxygen, if it is present at all, has probably to be administered by the crudest means, and as in the passages the light is poor, it is almost impossible to ascertain from the patient's colour whether he is or is not well oxygenated. Therefore, for this potentially most dangerous progress it is highly desirable that the most experienced person possible is in charge of the patient. In Hospital practice, however, it is very seldom possible for this condition to be met, but on the other hand, it is often the custom for a patient to be moved from the theatre to the ward in the hands of a quite untrained student.

I advise you all most strongly when you come to be responsible for giving anæsthetics yourselves, either to accompany your patients personally back to bed, as do all anæsthetists in their private practice, or failing this, to make sure that the person to whose charge you commit him shall be adequately instructed in the possibility of catastrophe which is always present in these circumstances. The golden rule should be never for a single instant to leave an anæsthetised patient unattended, particularly on a trolley. However well he appears to be breathing, at any moment his tongue may drop back and become obstructed, at any moment, especially if he is now but lightly anæsthetised, he may vomit and inhale vomited material into the air passages; he may even, by making a sudden movement, throw himself off the trolley. All these accidents may be avoided by the simple vigilance of all who are familiar with their possibility.

Similarly, when the patient has been returned to his bed any of these accidents may still happen at any time, as it may conceivably be some hours before he regains full consciousness. An experienced surgical ward sister is fully aware of every possibility, and will automatically take the right steps to guard against catastrophe, but, if you have to deliver your patient into the hands of an inexperienced nurse or male orderly, you will be well advised, if the patient is at all deeply anæsthetised, to place him in a lateral or semi-prone position, in which the tongue, if it falls, will fall forwards, and any foreign material, be it vomitus, blood or mucus, will trickle out of the corner of the mouth rather than into the pharynx. Furthermore, if the colour of the patient is not perfect, you will be well-advised to administer oxygen by an efficient method immediately, rather than wait for signs of the patient's anoxia to develop. While on the subject of oxygen administration, I should like to point out that oxygen cannot be given efficiently by means of a funnel held two inches from the patient's face. I would not insult your intelligence by mentioning this, were it not for the fact that even in this enlightened era

I have seen nurses administering oxygen in this way, under the fond delusion that the patient was deriving some benefit from it. Oxygen can only be administered efficiently by means, either of a well fitting face mask or nose piece, such as the B.L.B. or of nasal catheters. One other point of some importance in the nursing of immediately post-operative cases is that it is impossible to ascertain the true colour of a patient otherwise than in a good light. All too often I see patients being nursed in semi-darkness; in this condition the nurse cannot possibly tell if the patient is cyanosed.

Carbon dioxide should play only a small part in the resuscitation of anæsthetised patients. Nurses in this Hospital were formerly told that carbon dioxide should be administered to patients who were not breathing deeply; this, of course, is only the case where the respiration is shallow in the presence of a perfect airway. Now the commonest cause of apparently shallow respiration in these cases is obstruction of the air-way; obviously the first essential is to overcome the obstruction, and when this has been done it will be found that the breathing will immediately become deeper, as an excess of carbon dioxide will have accumulated in the lungs and blood-stream. It is one of the least edifying spectacles in surgery to see a nurse trying to improve a patient's condition by offering him a mixture of carbon dioxide and oxygen, when, in fact, all that she should be doing is to exert a slight upwards pressure on his jaw.

I have tried to suggest some of the accidents which may occur to an anæsthetised patient, accidents quite apart from those that may occur in connection with the actual administration. I have also tried to suggest the means by which such accidents may be avoided. It is your hope when you give an anæsthetic that the patient will survive; try also to see that he suffers no more injury in the course of it than that which is necessarily inflicted upon him by the surgeon.

Correspondence

Nurses' Appreciation

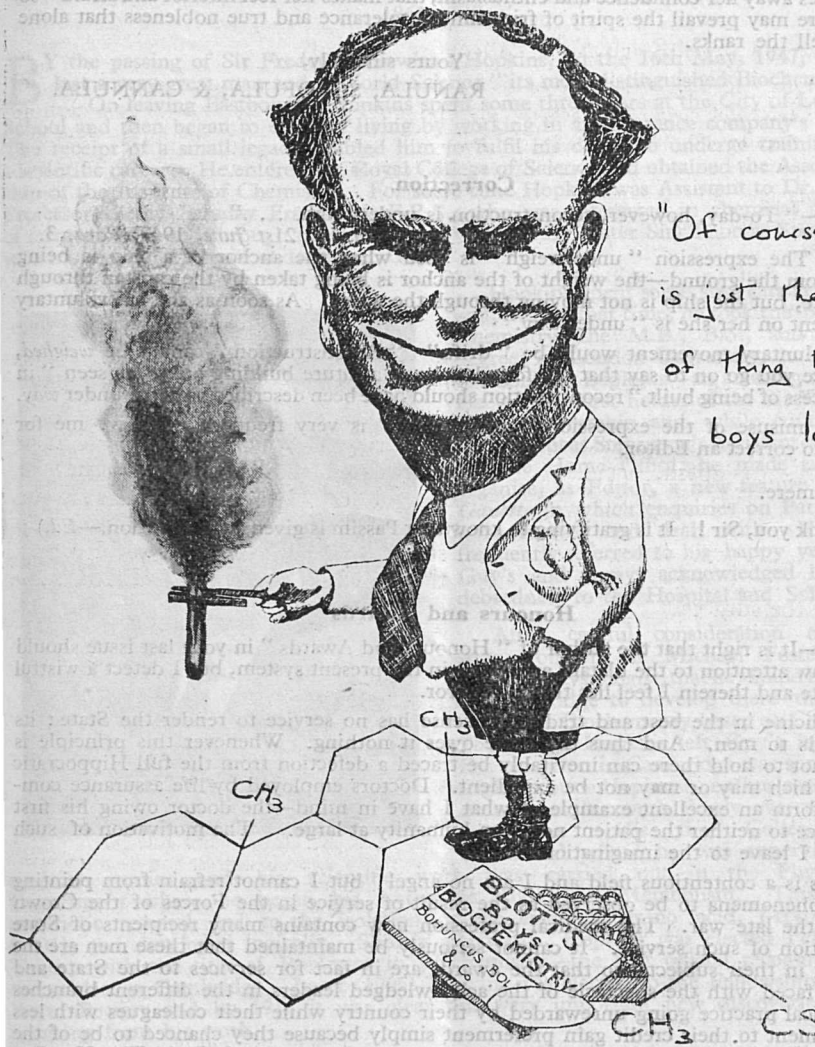
(We have received the following open letter to Dr. Vertue.)

DEAR DR. VERTUE,—We, the nurses, are deeply grateful that you should find time to write an appreciation of us, of our work and of our difficulties.

We therefore thank you for trying to refute the ideas that the vast majority of the public still holds about nurses in general, and we second wholeheartedly your description of nurses as they truly are, not as many would, with lack of sympathy and understanding have them be. The fact is indeed that we in our profession, surely more than any other women, have to be two distinct people—or, as you say, preserve our maternal love for our patients and develop our sexual love in our off-duty. Being essentially human people, many nurses find it difficult, at times almost impossible, to adjust themselves to this unnatural life.

We know too, as the general public and the Government apparently do not, that the solution to the nursing "slump" hinges not on increased pay and shorter hours, but on a more enlightened attitude towards us as women, and as youth, on the part of those in authority.

That a certain degree of discipline is essential, whilst on duty, is accepted, provided it is meted out with understanding and respect for our intelligence or ability. But it is the lack of freedom and social life off duty; the unequal struggle to preserve outside interests and friendships, (yes, even the best of friends grow a little weary of appointments being constantly postponed) which is doing so much to increase the disillusionment and discontent amongst us.


"Of course, this is just the sort of thing the boys love!"
CH3
CH3
BLOTT'S BOYS' BIOCHEMISTRY
BOHUNCUS, BOI & Co
CH3
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We fully realise that the time has come when we must unite against opposition, but we seek also the support and encouragement of those who, from the spectator's stand, can see the goal in clearer perspective than we who are taking part in the struggle.

Thus may it be that we see introduced into our hospitals in future years a new status for the student nurse—may she be treated as a student and not with the attitude that now takes away her confidence and enthusiasm, that makes her feel inferior and afraid—so that there may prevail the spirit of friendliness, tolerance and true nobleness that alone will swell the ranks.

Yours sincerely,

RANULA, SCROFULA, & CANNULA.

Correction

SIR,—" To-day, however, reconstruction is underweigh. . . ."

—*Passim*, 21*st June*, 1947, *Para.* 3.

The expression " underweigh " is used when the anchor of a ship is being lifted from the ground—the weight of the anchor is being taken by the capstan through the cable, but the ship is not moving through the water. As soon as she has voluntary movement on her she is " under *way*."

Involuntary movement would be " drift." " Reconstruction " cannot be *weighed*, but since you go on to say that the foundations of a future building are to be seen " in the process of being built," reconstruction should have been described as being under *way*.

The misuse of the expression " underweigh " is very frequent. Forgive me for daring to correct an Editor.

BASIL HALL.

Haslemere.

(Thank you, Sir ! It is gratifying to know that Passim is given such attention.—*Ed.*)

Honours and Awards

SIR,—It is right that the author of " Honours and Awards " in your last issue should draw attention to the blatant anomalies in the present system, but I detect a wistful note and therein I feel lies the basic error.

Medicine in the best and traditional sense has no service to render the State : its service is to men. And thus the State owes it nothing. Whenever this principle is found not to hold there can inevitably be traced a defection from the full Hippocratic ideal, which may or may not be expedient. Doctors employed by life assurance companies form an excellent example of what I have in mind—the doctor owing his first allegiance to neither the patient nor even humanity at large. The motivation of such activity I leave to the imagination.

This is a contentious field and I am no angel, but I cannot refrain from pointing to the phenomena to be observed as the result of service in the Forces of the Crown during the late war. The medical profession now contains many recipients of State recognition of such service. It cannot seriously be maintained that these men are the greatest in their subjects, so that the awards are in fact for services to the State and we are faced with the spectacle of the acknowledged leaders in the different branches of medical practice going unrewarded by their country while their colleagues with less achievement to their credit gain preferment simply because they chanced to be of the right age and with the appropriate qualifications on the advent of World War II. But I have already suggested that nothing is owing either way in the doctor-State relationship and that the doctor truly aware of his vocation would not deign to accept such rewards.

Now that we have become men let us put away childish things and, like Wilfred Trotter, scorn the bubble reputation and aspire to those feats of the mind and spirit whereby men may become truly great.

I am, etc.,

M. E. N. SMITH.

Guy's Hospital, S.E.1.

Obituary

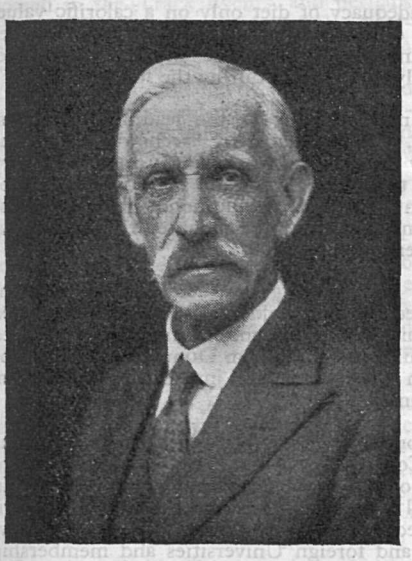
SIR FREDERICK GOWLAND HOPKINS,

O.M., M.A., Sc.D., D.Sc., LL.D., M.D., F.R.S., F.R.C.P.

1861–1947.

BY the passing of Sir Frederick Gowland Hopkins, on the 16th May, 1947, Guy's lost a very great man and "World Science" its most distinguished Biochemist.

On leaving Eastbourne, Hopkins spent some three years at the City of London School and then began to earn his living by working in an insurance company's office. The receipt of a small legacy enabled him to fulfil his desire to undergo training for a scientific career. He entered the Royal College of Science and obtained the Associateship of the Institute of Chemistry. For some time Hopkins was Assistant to Dr. (later Professor) Percy Faraday Frankland, F.R.S., who was interested in chemical studies of fermentation, and through Frankland, Hopkins met Dr. (later Sir) Thomas Stevenson who invited him to come and work at Guy's.



Hopkins spent some six years at Guy's and, during that time, he took the B.Sc. in Chemistry, the M.B., B.S., and D.Sc. degrees of London University, as well as the Conjoint Diploma—an amazing record. He was the first holder of the Sir William Dunn studentship and, while continuing throughout as Stevenson's Assistant on work for the Home Office, he made time to organise, as Editor, a new feature of the *Gazette* in which enquiries on Pathology were invited and dealt with. Hopkins frequently referred to his happy years at Guy's and always acknowledged his indebtedness to the Hospital and School.

After careful consideration of the suggestion of Sir Michael Foster, the eminent physiologist, that he should migrate to Cambridge to develop there the new subject of Biochemistry based on Chemical Physiology, Hopkins left Guy's in 1896. His reception in Cambridge was somewhat frigid; but Hopkins' enthusiasm and devotion to his work slowly overcame the opposition. His first College was Emmanuel where he was supervisor in medical studies and his scientific work was carried out in the Physiology Department where he began his systematic studies on Metabolism. This early metabolic research led to the isolation of the essential amino acid, *l*-tryptophan (1901), and developed logically. Shortly afterwards, Hopkins was elected Fellow of Trinity with the title of Prælector in Biochemistry—the first official recognition of the subject in Cambridge. Later (1905) Hopkins was elected to the Fellowship of the Royal Society and by 1911 it was clear that very important new discoveries were resulting from his work.

Curiously enough, it was in the early stages of the generally ill-considered controversy on "Standard Bread" in 1911–1912 that Hopkins made his preliminary announcement: "There may be certain substances elaborated by the living cells of the plant which cannot be readily synthesised by the animal body. Their quantity cannot be considerable, and, if they are present, and their chemical nature entirely problematical, it may be that they are nevertheless of value." The positive occurrence of what Hopkins then designated "accessory factors in a dietary" was announced by him in 1912 (*J. Physiol.*, **44**, 425). "Groups of young rats were fed on a basal diet of caseinogen, fat, carbohydrate and salts and compared with other rats on the same

diet plus a minute ration of fresh milk. The former soon ceased to grow and the latter grew normally. The consumption of food was practically the same throughout, but the milk addendum reduced the food necessary for a given increment in weight to one-half or less. Cessation of growth occurred before loss of appetite appeared." What the actual substance(s) are in the milk which thus markedly affect growth was then, of course, not known.

Such is the early history of this important work which Hopkins continued to develop. The term *vitamine* (later and now-a-days, *vitamin*) was suggested by C. Funk to designate the substance or substances without which in a rice diet beri-beri ensues. Hopkins continued to use his own term until definite evidence of these factors being chemical substances was obtained by him, when he accepted *vitamin* as the general name for all these factors. Hopkins' work was chiefly concerned with vitamins A and B and subsequent work led to other discoveries in this field and the vitamins were called C, D, etc., in order of their discovery. Subsequent work has shown that certain of these main classes are complex, particularly B, D and K.

After the " Standard Bread " discussion the only other public controversy in which Hopkins reluctantly engaged and carried on from 1914 onwards was in connection with the standard of an adequate diet. His own investigations and those of many others had shown the importance of the " accessory food factors " for a healthy diet and that it was biologically wrong to base adequacy of diet only on a calorific value. He clearly recognised, however, the difficulty of numerically estimating real food values but his work did result in the Government taking steps for the provision, as far as possible, of essential vitamin-containing foods, especially for children during the food crises.

By this time Hopkins was recognised internationally as the leading Biochemist and in vitamin research he was pre-eminent. While vitamin research was always the major theme of Hopkins' work he made very important contributions to the chemistry of Muscle Metabolism and he was the first to isolate (1921) and investigate the properties during several years of the important tripeptide, glutathione—the co-enzyme of glyoxalase. For his scientific work mankind will always be indebted to him and his name is among those of the Great Men of Science.

A special professorship of Biochemistry at Cambridge was created for Hopkins in 1914. This lapsed when he was appointed the first holder of the newly instituted Sir William Dunn Professorship of Biochemistry in 1921, and from which he retired in 1943. The newly built and excellently equipped Sir William Dunn Institute became the leading research school in Biochemistry in this country, and investigators came from many parts of the world to work with Hopkins.

Hopkins was knighted 1925 and other honours quickly followed. He received the highest honour of the Royal Society—the Copley Medal—in 1926, the Nobel Award in Medicine in 1929, and the Albert Medal of the Royal Society of Arts in 1934. In 1930 Hopkins became President of the Royal Society and received the Order of Merit in 1935. His academic distinctions included honorary doctorates in Science, Laws and Medicine from some seventeen British and foreign Universities and membership of some thirteen foreign Academies. These are only some of the honours which were awarded to and so richly deserved by him. In public service, he was an original member of the Medical Research Council, member of the Agricultural Research Council and Chairman of the Animal Diseases Committee of the Economic Advisory Council.

Hopkins was a man or great charm and his friendship was highly esteemed by a large number of colleagues and especially by those who worked with him. Extreme modesty was a characteristic trait and his readiness to attribute ability and high motives to others occasionally led his judgment astray ; but the few errors he made in estimating the capacity of others were more than compensated by his choice of the large number of brilliant and loyal colleagues with whom he built up the magnificent record of investigations carried out in his Institute.

The record of Sir Frederick Gowland Hopkins' achievements must be almost unsurpassed among biologists of his generation. The benefits to mankind resulting from his work are incalcuable. To have known him was a very great privilege and it is an honour to pay tribute to his memory.

CHARLES S. GIBSON.

Sport

ATHLETICS

Guy's won the Championship Shield at the 69th Annual Inter-Hospitals Athletic Sports Meeting, which was held at Motspur Park on June 21st, 1947.

Of the seventeen events, Guy's won seven and came second in four others. This was a highly satisfactory performance and that, in no small measure, to the enthusiastic and kind-hearted endeavour of B. G. B. Christie, who succeeded in getting together a well-balanced team and in reconstituting the Athletic Club *en passant*.

The more spectacular successes were scored in the Track Events, and perhaps the two finest performances of the afternoon, certainly the two best to watch, were those of the South African runners, D. J. Joubert and E. Mackenzie, who won the 440 yds. and the 880 yds. respectively. Joubert is already well-known in this country, and once he has fully recovered from his leg injury, which has handicapped him for two seasons now, he will seriously challenge many of Great Britain's foremost runners. Mackenzie, who won the 880 yds. in under two minutes and might have broken the record had he been pressed, is a really beautiful middle-distance runner, and should accomplish great things in the near future.

Another excellent performance was that of C. R. E. Baker, who set a very fast pace in the 220 yds. and would have won comfortably if he could have maintained it. B. Hartley ran a fine race in the Mile, with a well-judged final lap, to record his fastest time over this distance.

In the Field Events, that worthy perennial, J. Southgate, won the Hammer and was fourth in the Weight. F. Retief was unfortunate to be placed second in the High Jump. He cleared the same height as the winner, but took one more jump to do it. In the Long Jump, D. Le Clus beat J. D. J. Havard—no mean feat. N. A. Rawlinson, of U.C.H., threw the Javelin 170 feet 5½ inches and created a new record. P. T. C. Rowan won the Pole Vault.

London Hospital had no opponents in the Tug-of-War until Guy's accepted their challenge and fielded a veritable *pot-pourri* of types, who went down with flying colours, gaping waists and flapping tongues. In the final event—the Mile Medley Relay—Guy's romped home, none of the four runners, except the first, having to exert himself.

Thus ended a gratifying afternoon. Two famous Guy's athletes of past years, Dr. Munro and Mr. Kelsey Fry (President of the Athletic Club) were there to see Guy's win, and their presence was much appreciated by the team.

The results were as follows :—

100 *Yards*—1 J. D. J. Havard (Middlesex); 2 D. J. Joubert (Guy's). 10.4 secs.

220 *Yards*—1 J. D. J. Havard (Middlesex); 2 C. R. E. Baker (Guy's). 23.0 secs.

440 *Yards*—1 D. J. Joubert (Guy's); 2 B. R. J. Simpson (London). 51.3 secs.

880 *Yards*—1 E. Mackenzie (Guy's); 2 W. E. Machaelburg (Thomas's). 1 min. 59.5 secs.

Mile—1 B. Hartley (Guy's); 2 J. B. Millard (King's). 4 mins. 33 secs.

Three Miles—1 J. A. Menon (Bart's); 2 D. Ryder-Richardson (London). 16 mins. 4.8 secs.

120 *Yards Hurdles*—1 T. R. Beatson (Mary's); 3 B. C. B. Christie (Guy's). 16.5 secs.

440 *Yards Hurdles*—1 T. R. Beatson (Mary's); 3 B. Hartley (Guy's). 60.3 secs.

High Jump—1 J. Boothman (Thomas's); 2 F. Retief (Guy's). Both 5 ft. 7 ins.

Long Jump—1 D. Le Clus (Guy's), 2 J. D. J. Havard (Middlesex). 21 ft. 6 ins.

Pole Vault—1 P. T. C. Rowan (Guy's); 2 J. M. Burdenell (King's). 7 ft. 6 ins.

Putting the Weight—1 J. Le Bouvier (Middlesex); 4 J. Southgate (Guy's). 36 ft. 8 ins.

Throwing the Hammer—1 J. Southgate (Guy's); 2 K. L. Oldershaw (London). 77 ft. 9¾ ins.

Throwing the Javelin—1 N. A. Rawlinson (U.C.H.); 4 C. Schiller (Guy's). 170 ft. 5½ ins.†

Throwing the Discus—1 K. L. Oldershaw (London); 4 D. J. Joubert (Guy's). 113 ft. 3¼ ins.

Tug-of-War—Winners : London Hospital. Runners-up : Guy's.

Mile Relay—(220×220×440×880). 1 Guy's (Long, Baker, Joubert, Mackenzie); 2 Middlesex.

CHAMPIONSHIP SHIELD.

1. Guy's Hospital .... 53 pts.
2. { London Hospital .... 35 pts.
   { Middlesex Hospital..... ..... 35 pts.

† New record.

R.H.N.L.

GOLF

STAFF *v.* STUDENTS MATCH.

This match was played for the first time since the war at Sidcup, on Wednesday, June 4th. Despite the fact that many of the Staff said they had not touched a club for years, most of the matches were very close and a most enjoyable afternoon was had by all and we hope to have a return fixture in the near future.

Results of matches :—

Staff.		*Students.*	
Dr. J. Whillis .. / Dr. K. S. Maclean	0	W. Vans Agnew .. / D. F. Cottier ..	1
Dr. F. A. Knott .. / Mr. A. Bulleid ..	0	J. M. D. Grant .. / J. K. Anderson ..	1
Dr. J. G. Mathewson / Dr. J. C. Houston	0	D. M. Griffith .. / N. E. Price ..	1
Dr. G. Stoddart .. / Mr. N. L. Eckhoff..	0 / 0	J. L. Harrington .. / J. D. Crowlesmith	1
Mr. J. B. Blaikley ..		C. J. G. Menzies .. / G. Nicholson ..	1
Mr. W. D. Doherty	1	M. J. Quelch .. / G. E. Moore ..	0
	1		5

MATCH *v.* MIDDLESEX HOSPITAL AND INTER-HOSPITALS CUP.

These events were played concurrently at Sundridge Park on Wednesday, June 11th. We won the match with Middlesex by 5 games to 1 with one halved.

Results of games were :—

Middlesex.		Guy's.	
Jones	0	J. M. D. Grant 7/5	1
Crew	0	D. F. Cottier 6/5.....	1
Savory	½	J. K. Anderson, All sq.	½
Brown	0	D. M. Griffith 3/2	1
Cotton	0	N. E. Price 6/4	1
Crawford 4/3	1	J. D. Crowlesmith	0
MacIver	0	J. L. Harrington 4/3	1
	1½		5½

The Inter-Hospitals Cup was competed for by a team of 6 from each of the Hospitals. The winners being the team with the lowest aggregate gross score. The finish was quite exciting when, each with their last man to come in, Guy's were leading the field, being 1 stroke ahead of St. Thomas's. However surprisingly enough, " Tommies " last man returned the best score of their whole team whereas, unfortunately, our last man did not! It was a most enjoyable meeting and St. Thomas's were worthy winners with an average score for their team of 86, bogey being 76.

PRESIDENT'S PRIZE.

This fixture was played in the rain at Sidcup on Wednesday, June 18th. In spite of the weather there was a very good entry. We were pleased to see several newcomers taking part and we look forward to seeing even more in the next competition. Dr. Knott, our president, most generously awarded prizes for the winner and runner-up.

Leading results were :—

Winner—D. F. Cottier (9) ..... 34 pts.

Runner Up—N. E. Price (8) ..... 33 pts.
J. M. D. Grant (3) 31 pts.
J. C. Crowlesmith (16) 29 pts.
J. K. Anperson (10) 27 pts.
D. M Griffith (10) 27 pts.

" MEDICALS *v.* DENTALS."

(Wednesday, June 25th.)

Both sides were well represented and we played 4-ball matches on handicap.

There were some very close games, and the " Dentals " just won by 2 matches to 1 with one halved.

J.M.D.G.

CRICKET

GUY'S *v.* HAMPSTEAD C.C.

(at H.O.P., 31st May)

Result : Drawn.

Guy's : 171 for 9 declared (Munro 23, Nicholson 44, Dyer 24).

Hampstead : 126 for 8 wkts. (O'Driscoll 4 for 27).

GUY'S *v.* FINCHLEY C.C.

(at Finchley, 1st June)

Result : Lost by 3 wkts.

Guy's : 153 (Nicholson 51, Williams 21, Munro 20).

Finchley C.C. : 158 for 7 wkts. (Woodford 3 for 33).

GUY'S *v.* GREENWICH C.C.
(at H.O.P., 7th June)

Result: Won by 8 wkts.

Greenwich : 138 (O'Driscoll 3 for 42, Russell 3 for 50).

Guy's : 141 for 2 wkts. (Nicholson 21, O'Gorman 75 not out, O'Driscoll 35 not out).

GUY'S *v.* AMERSHAM C.C.
(at Amersham, 15 June)

Result: Lost by 5 wkts.

Guy's : 135 for 7 dec. (Williams, 40; Graham 27).

Amersham : 136 for 5 wkts. (Woodford 3 for 43).

2nd ROUND HOSPITAL CRICKET CUP

GUY'S *v.* ST. BARTHOLOMEW'S HOSPITAL.

(*At H.O.P., June 18th*, 1947)

Result: Guy's won by 36 runs.

Guy's won the toss and decided to bat on a hard true wicket. The opening batsmen played the Bart's attack steadily, and 20 runs soon appeared on the score board.

The Bart's bowling was accurate and with the score at 21, Vazifdar, the Indian bowler, dismissed Billingham. Gilbert was then well caught in Vazifdar's leg trap, and two more wickets fell quickly with score at 46.

Williams, who had been batting confidently, was then joined by Graham and the score increased until Williams was rather unluckily caught for 34 very valuable runs.

The wicket became slower and easier as a fine drizzle of rain descended throughout the rest of the morning. Lunch was taken with the score 82 for 5 wkts.

After Lunch, Nicholson proceeded to score freely until he was bowled by a good ball for 34. The last three Guy's wickets fell very quickly and the side were all out for a total of 148.

St. Bart's began their innings after tea against the bowling of Russell from the Football stand end and O'Driscoll. Morgan, the Bart's captain, quickly hooked Russell three times to the fine leg boundary.

Shortly afterwards Guy's obtained three quick wickets. Morgan was l.b.w. to O'Driscoll, Biddell very smartly caught in the slips by Russell off O'Driscoll's bowling, and Vazifdar caught off Russell without scoring.

Meanwhile Tomlinson had been batting very well. Small and compactly built he scored 53 runs before having his off stump removed by O'Driscoll. Derbyshire have a fine batsman in this young man.

The Bart's score then stood at 85 for 6 wkts., and the later batsmen offered little resistance—O'Driscoll taking the ast 4 wickets in five overs for the cost of five runs.

Score : Guy's 148 (Williams 34, Nicholson 34).

Team : J. D. Williams (Capt.), R. G. Nicholson, E. W. Graham, A. M. Platt, H. M. C. O'Driscoll, G. P. Billingham, P. S. Holmes, R. S. Russell, J. F. Woodford, M. C. Gilbert, H. E. Dyer.

TENNIS

In the second round of the Inter-Hospitals Cup Tie, Guy's beat U.C.H. on Wednesday, 25th June, 1947, at H.O.P.

Results—Singles :—

1. I. Kelsey Fry	..... won	9—7	6—0
2. K. M. Hume	..... won	11—9	6—3
3. E. Searle	..... won	6—3	6—0
4. R. Merrill	..... won	6—0	6—1
5. D. le Clus	..... won	6—0	6—1

P. Carton-Kelly. Not played.

In the doubles, I. Kelsey Fry and K. M. Hume beat their first and third pairs by 6—3, 4—6, 6—2 and 6—1, 6—1 respectively. P. Carton-Kelly and E. Searle won against their second and first pairs by 6—2, 6—1 and 4—6, 6—4, 6—4 respectively. R. Merrill and P. R. Chalk beat U.C.H. third and second pairs by 6—2, 2—6, 6—3 and 6—1, 6—3 respectively. The result at the stop of play was a win for Guy's by eleven matches to noqe.

K. M. HUME,
(*Hon. Sec.*).

Hospital Information, etc.

NOTICES

GUY'S HOSPITAL MEDICAL SCHOOL.

Applications are invited for the appointment of Assistant to the Director of the Department of Pædiatrics. The appointment is for two years in the first instance, to commence in September. Applicants should hold the M.D., or M.R.C.P. Salary £750–£1,000 per annum, with superannuation and family allowance. Copies of Standing Orders for the appointment are obtainable from the Dean, to whom ten copies of application with the names of three referees should be forwarded not later than 26th July, 1947.

DEPARTMENT OF SURGERY.

On Saturday, July 5th, Mr. Batchelor will be conducting a demonstration of Orthopædic Procedures at Orpington. A bus will leave the front quadrangle at 9.15 and will be back by 12.45.

On Tuesday, July 8th, there will be a demonstration in the series "Operative Procedures" at 12 noon in Theatre 2.

On Saturday, July 12th, at 10 a.m., Mr. Eckhoff will conduct a Departmental Round in Queen Ward.

On Tuesday, July 22nd, there will be a demonstration in the series "Operative Procedures" in Theatre 2 at mid-day.

During the latter half of July there will be an exhibition in the Gordon Museum, illustrative of the "Surgery of Carcinoma of the Breast."

GUY'S THEATRE CLUB.

"The Duke in Darkness," a play in three acts by Patrick Hamilton (author of "Rope") will be presented in the Physiology Theatre on the following dates:—

Wednesday, August 6th, at 8.15 p.m.
Thursday, August 7th, at 6.0 p.m.
Friday, August 8th, at 7.45 p.m.
Saturday, August 9th, at 2.30 p.m. and at 7.45 p.m.

As usual, admission is free to those connected with the hospital and their friends. But once again it is hoped that contributions will enable the Committee not only to cover expenses but to make a substantial contribution to the Hospital Wireless Fund.

Seats may be reserved by applying for tickets to the Hon. Sec., Theatre Club, Guy's Hospital, S.E.1.

PASS LIST

UNIVERSITY OF CAMBRIDGE.

SECOND M.B.

Anatomy and Physiology.

Easter Term, 1947.

J. W. B. Dalgleish.

FINAL M.B. EXAMINATION.

Easter Term, 1947.

PART I.

Surgery, Midwifery and Gynæcology.

A. F. Crick	D. B. Sugden
J. G. Goodhart	S. M. Vine
J. H. Inskip	D. Walker
M. H. Lessof	A. R. H. Worssam

Part II.—Principles and Practice of Physic, Pathology and Pharmacology.

W. H. Barker	J. L. Moffatt
A. F. Crick	J. M. Palmer
N. B. Finter	E. P. H. Shortt
J. G. Goodhart	

EXAMINING BOARD IN ENGLAND.

June, 1947.

D.L.O.

K. L. Wilson.

CONJOINT BOARD.

PRE-MEDICAL EXAMINATION.

June, 1947.

Chemistry, Physics and Biology.

R. R. Alsop	A. W. McCandlish
K. Ballantyne	D. G. Matthews
S. G. Brangwin	S. F. Mitchell
H. Carter	H. R. Prentice
W. D. P. Flynn	F. Roth
A. G. Gapper	E. G. Searle
J. M. Hobbs	M. S. Tyrell
D. G. James	P. W. P. Warren
R. B. Jones	A. E. Woods

Chemistry.

S. G. Baker	F. Quail
C. J. Bayley	G. K. Taylor
P. T. Burke	D. W. Thomas
T. B. Forward	A. V. Westlake
D. J. Neill	R. B. Whalley
K. H. Pickup	G. F. Willcox

Physics.

S. G. Baker	D. J. I. Jones
F. G. Brown	P. M. Rusden
P. T. Burke	G. K. Taylor
M. H. Ede	A. V. Westlake

Biology.

K. S. Chambers	D. J. Neill
H. de V. Davis	K. H. Pickup
M. H. Ede	D. W. Thomas
J. R. Flynn	A. H. Whitaker
D. J. I. Jones	G. F. Willcox

SOCIETY OF APOTHECARIES OF LONDON.

FINAL EXAMINATION.

June, 1947.

Pathology, Bacteriology and Forensic Medicine.

A. A. Collis	E. L. W. Leiser
*A. R. Ellerker	J. A. Stewart

Medicine.

A. A. Collis	E. L. W. Leiser
*A. R. Ellerker	J. A. Stewart

* Has completed the examination.

BIRTHDAY HONOURS.

Knight Bachelor.

William Norwood East.

O.B.E. (Civil).

Patrick John Monaghan.

TATA MEMORIAL TRUST.

Dr. Peter Gorer has been awarded a grant for research expenses and assistance for research in blood diseases with special reference to leukæmia. The award will be made by the trust in October.

APPOINTMENT

UNIVERSITY OF OXFORD.

Dr. R. V. Coxon has been appointed Betty Brookes research fellow for three years, from October 1st, 1947.

PAPERS BY GUY'S MEN

Allsopp, C. B. The effects of Lewisite and of Lewisite Oxide on Living Cells in Vitro. *Brit. J. Exp. Path.*, 1946, **27**, 305.

——. The Therapeutic effect of British Anti-Lewisite (B.A.L.) on Tissue cultures Grown in a medium containing Lewisite Oxide. *Ibid.*, 310.

CHANGE OF ADDRESS

A. Bowen Davies, F.R.C.S., 49, Harley Street, W.1. (Tel.: Welbeck 9721.)

BIRTHS

MAYNE.—On June 27th, 1947, to Frances (née Watson), wife of Dr. A. H. Mayne, of Three Corner Park, Calstock, Cornwall—a son (Peter Humphrey).

SICHEL.—On June 20th, 1947, at Northampton, to Betty, wife of G. R. McK. Sichel—a daughter (Jennifer Kathleen), sister for Barbara Ann.

STAFFORD-CLARK.—On May 22nd, 1947, at Nuffield House, to Dorothy (formerly Stewart, née Oldfield), wife of D. Stafford-Clark, M.D., M.R.C.P.—a brother (Jonathan) for Maxwell and Priscilla.

WALLACE.—On June 12th, 1947, at Wilmar Lodge, Epsom, to Maureen (née Robarts), wife of C. J. Wallace—a son.

ZORAB.—On June 20th, 1947, to Janet, wife of Edward C. Zorab, of 20, Brunswick Place, Southampton—a daughter.

DEATHS

WITTS.—On April 11th, 1947, Charles Witts, M.C., M.B., B.S., of Edgbaston, Birmingham, aged 62 years.

Eds. { D.H.F. / H.A.R.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

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PASSIM

IT is common when reading original articles in the medical journals to see at the commencement of the terminal paragraph such words as "I am indebted to . . ." or "I wish to thank . . ." Thereby proper appreciation is given to masters for criticism and advice, to juniors for faithful donkey-work, to chemists for the supply of drugs, and occasionally to the nursing staff for scrupulous attention to such details of care as may be demanded by the condition of the patient or the idiosyncracies of the surgeon. How often does one read, however, "I wish to express my thanks to the anæsthetist, without whose assistance these operations would not have been possible," or "without whose help these results would not have been obtained"? I cannot recall having seen such justice done.

For justice it is. One cannot pass fair comment on recent advances in surgery without paying respect to two great adjuvants, the one chemotherapy, the other anæsthesia. No good surgeon fails to assess the contribution they make to his success. A number of less good surgeons are even more in their debt.

Whether or not justice is done in print is of small import. What matters is whether respect is paid in practice. A careful consideration of the anæsthetists' desires and difficulties would not only be a courteous recognition of their contribution to a modern operation, but by enabling them to achieve their optimal results, would in the end benefit the patient—the yardstick by which all endeavour must be measured.

> "The patient's anæsthesia starts from the moment at which he receives his pre-anæsthetic injection, in his bed. This pre-anæsthesia can be an extraordinarily pleasant experience . . . in which he is dulled of almost all apprehension . . ., the result of lack of quiet may be rather to produce hypersensitivity."
>
> E. H. RINK.

> "The patient, still under the anæsthetic, after the operation has been completed, should be subjected to a minimum of movement."
>
> BRIAN D. JOHNSON.

We quote from two recent issues of this journal. Attention is drawn to an aspect of anæsthesia which the anæsthetists consider of importance, a phase over which they have little control, and to a way, therefore, in which we can assist them to achieve the high standards of which they are capable.

The pre-medicated patient is seldom treated with the care that Dr. Rink considers desirable. The pre-anæsthetic injections having been given, the fact that analgesia, amnesia and narcosis have commenced tends to be lost in the business of ward routine and in seeing the preceding case off to the operating theatre. The patient's transport from bed to trolley too often resembles the unloading of cargo at the dock-side, with a heave and a ho! The manner of his carriage from the ward to the theatre seldom has appearances which differentiate him from any other patient being wheeled along, may be,

for a routine X-ray. Good cheer and chatter are great adjuvants to the second, but can be nowhere but out of place in the first.

No one who has had a nitrous-oxide induction can fail to have noticed how the slightest noise re-echos and rebounds around the mind. A slight creak acquires the characteristics of a buzz-bomb, a quiet tapping—the explosion of shell-fire, and a whisper may sound like the cacophony of a thousand voices. While over all one tries to go to sleep. Too often, for the hospital patient, it must be too difficult.

Here then is great scope for improvement in our ways. From the moment the patient receives his pre-medication he must be treated as the anæsthetists would have us do. He must have absolute quiet and absolute rest. If this is constantly born in mind by everyone, however peripheral their position in the surgical circle, a great advance will be made over our present standard of conduct. But two points require the consideration and action of higher authority. We trust that the departments of surgery and anæsthesia will take up the matter.

In the first place, surely in this enlightened age it must be regarded as a disgrace that an anæsthetised patient has to be wheeled from the operating theatre at the top of the surgical block, to a bed in Mary Ward, at the top of Hunt's House. Secondly, surely the time has come when our manner of lifting the patient is obsolete. A trolley should have been devised by now, of which the stretcher could be layed under the patient before pre-medication, which not only will enable the dressers to lift him from his bed, asleep if necessary, gently at least, but later will serve to move him on to and off the operating table, and finally back to bed.

Contemporary surgery could not possibly be what it is without the high standards of contemporary anæsthesia. Knocking the patient out has long ceased to be enough. Knocking the patient about, too, must become out of date.

WE apologise for an error in Hospital Information of the last issue. Under "Regional Hospital Boards" the words *North* East Metropolitan Region should read *South* East Metropolitan.

Obituary

RONALD M. J. FRANKS.

WITH deep regret we have learned of the death, on July 18th, 1947, of Dr. Ronald Michael Jack Franks.

Ronnie Franks, who was in his thirty-first year, came to Guy's from South Africa in 1933, and qualified in 1940. After taking his Finals he filled the appointment of House Physician at the Joyce Green Hospital, Dartford, Kent, and in 1941 was commissioned in the R.A.M.C. Following a short spell of service at home, he was posted to the Pacific with a General Hospital, and was one of that unfortunate band who saw, not the glamour of the tropics, but only the last humiliating scrambles as Singapore fell.

In these unhappy circumstances he was not only a hard-working doctor who did more than pull his weight, but had, in addition, that extra something which none of us can expressly describe, but which unmistakeably labels a man as good company. In the times that were to follow there were many of his colleagues who could attribute some lightening of their lot to Ronnie's unfailing humour and good fellowship. Three and a half years as a prisoner-

of-war is a little life-time, and friends who met Ronnie on his return from his Japanese adventure marvelled at finding him so little changed. They would not have guessed that, in his prison camp, he had had more than his fair share of illness. Nor could they have guessed that his life, then wonderfully restored to him, was to be taken away so quickly.

At the time of his illness he was working for Part II of the Diploma in Radiology, having been successful in Part I in March of this year. He is survived by his widow whom he married in South Africa during his repatriation leave before returning to Great Britain. To her in her loss we tender the sincere sympathy of Guy's Hospital and of the Medical School where, we should like her to be assured, her husband's memory will not quickly fade.

A.C.G.

Old Age

A Clinical Lecture given on May 16th by CHARLES BAKER, O.B.E., M.D.

GENTLEMEN,—Apart from the occasional case of emergency you do not often have the opportunity for studying illness in the very old in the wards of this Hospital. This is understandable and unavoidable, for we tend to use the limited number of beds at our disposal for cases where active treatment is imperative, and in order to deal with as many of these as possible we cannot afford to block a bed with an old person in whom the medical changes are slow and treatment is of long duration. This is to be regretted, for medicine in the old differs as much from medicine in the young and middle aged as does medicine in children, which is rightly treated as a speciality and in which you have a definite appointment. In fact you will have noticed that yet another speciality is appearing, that of Geriatrics—a word which was first coined in 1914 in America, where this branch of medicine has received special attention, from the Greek *geron*, an old man, and *iatrikos*, skilled in the medical art, on the analogy of pædiatrics the study of childrens' diseases. Though I doubt whether the medical treatment of old people justifies the whole-time attention of one specialist as does pædiatrics, it is an important part of medicine and one that will increase in importance. With improved social conditions and advances in treatment, particularly in the last few years with the protection against infection offered by chemotherapy, the expectation of life has risen considerably in this country and will continue to rise. We are an ageing nation, for while in 1931 10 per cent. of the population was over 60 years, it was estimated in the Beveridge Report that by 1971 this proportion will have risen to 20 per cent.

I do not propose to embark on the wider subject of Gerontology, which comprises all the aspects of old age, social, cultural, economic and psychological, but it is of course difficult not to touch on some of these points, which cannot be divorced from reasonable and rational medical treatment. There has been a growing interest and sense of responsibility for the problems of the old and for a comprehensive review of this subject you should read the recently published survey of the Nuffield Foundation. The Goodenough Report on the future organisation of medical schools has also suggested that in the future 1,000-bedded teaching hospitals, some beds should be allotted for the chronic sick and aged and that, at some time in his medical training, probably in the projected pre-registration house appointments, the student should gain some experience of the problem of dealing with the aged both in the home and in special institutions which care for them.

The treatment of old age and its diseases is not easy and an old and

experienced family doctor would, and in the case of many of you, probably will, give you much better advice than I can. It is only because in the hospital where I worked before returning to Guy's I had the opportunity of observing and treating illness in the aged, that I venture to choose this subject for my first clinical lecture.

THE HISTORY.

It is often difficult, and may be impossible, to obtain a connected history from the old, and one has often to rely on the observations of relatives or friends. For the essentials of the history this is often an advantage, for old people tend to be obsessed by a particular symptom (usually their bowels), often quite unconnected to their illness, and are often unaware of their general condition; on the other hand the relatives can usually furnish the information which is so important, such as the onset and duration of physical and mental failure, general state of health, strength, and change in weight and appearance. But whenever possible a history from the patient himself should be obtained, though it requires patience and may have to be spread over several visits. The history tends to be even more rambling and disconnected than often occurs in the young or middle aged and reminiscences of past medical experiences and what the doctor said thirty years ago are apt to be even further from the point than in most patients, for the old remember the past clearly and forget recent events. You must bear with this, for not only are the old very critical of the young doctor and judge him by the interest in what *they* consider the important features of their case, but these irrelevances are often the clues to a successful management of the patient. Personal contact and mutual respect are essential, for you must remember that in the old you are usually called upon to handle the case for a long period rather than to prescribe a specific course of treatment that will quickly effect a cure. The old are not really interested in the present except to compare it unfavourably with the past and it is in their past so often that the necessary liaison must be established. The three things they are most interested in are old surroundings, their past work, and their children. In any case you must have something to talk about, if there is little that you can do, nor is this mere humbug and "bedside manner." Much can be learnt of medicine, and more of life, in the past history of the senile and I have often wished that I could have done more in the way of effective treatment to repay the knowledge and interest that I have gained from what on first acquaintance appeared to be a rather dull and boring old incontinent. The old have fixed notions about health and disease and because of their years often consider themselves experts in the art of living. They must be handled tactfully and you must not try to explode the medical misconceptions of the chronic sufferer: you will not succeed and even if you did, you would deprive them of a thing they prize. We know that recurrences of malaria do not continue throughout life without reinfection, but when confronted with the aged taipan or retired soldier, don't say that his recurrent winter coryza isn't Malaria; in any case he has some reason in that he responds to infection in a malaria-like way and is relieved by quinine. Nor does it do any good to tell the old lady whose only interest in life is her lower bowel, that there is no such thing as Colitis.

THE EXAMINATION OF THE PATIENT.

To examine an adult patient a thorough observation from the end of the bed, made before the closer examination with hand and stethoscope, is an essential step in arriving at a diagnosis. You will have learnt that this distant

prospect is even more important in the case of children. With the aged it is often the most important part of the examination for not only may it be the only clue that something is wrong, but on this general impression of vitality the treatment and the prognosis depends. These are some of the questions that you must ask yourself in your general observation :—

1. *How alive is the patient* ? Does he maintain his posture in bed or does he slump into a heap ? Is the head firmly held or does it flop or jerk with every respiration ? Is there any attempt at movement or change of position, or is there a complete and passive immobility ? How firm is the voice or is there any slurring or difficulty in speech ? If he is ambulant, how supple is the gait and how easily are changes of posture made ?

2. *Does the patient look his age* ? If the skin contours are rounded and the texture is firm with the appearance that blood actually circulates in it, this appearance of relative youthfulness is a good sign whatever the actual age. The sagging contours, prominent bones, and lined, dry, parchment-like skin which give an appearance of senility beyond the number of years is a bad sign.

3. *How aware is the patient of his surroundings*? Does his face show any expression ? Have the eyes any spark ? Does the patient know that he is ill ? Does the patient appear preoccupied or is there any reaction to the interest shown in him ? Are there any signs of confusion or delirium ?

These are three important points to establish. An old person who shows vitality, looks younger than his age and shows a normal reaction to the environment has much in his favour whatever his illness. Any old person who is totally immobile, looks older than his years, and shows no response to his surroundings has a very poor outlook, however much there may be to offer in the way of treatment.

You will, of course, make note of the skin colour, but remember that many old persons, particularly the emphysematous, have a permanent tinge of cyanosis. Changes in respiration, in rhythm as well as in rate, are very important, for a heightened respiration may in the old be the sole indication of pneumonia and changes of rhythm in breathing are a sign of heart failure which are sometimes missed. A rhythmic tremor of the head and hands is common enough to be of no significance but the restless twitchings of the hands and purposeless movements—signs of anoxia—are usually terminal signs.

In addition to this careful observation it is important to inquire from the relatives or nurse whether there has been any recent change in temperament. An unaccustomed irritability and grumpiness or the development of unfounded complaints are often signs of the onset of illness. Equally it is of grave import when the tiresome and tetchy old lion begins to lie down and behave like a lamb. It is because nurses and relatives are more observant of these general points in appearance and behaviour that they are so often better at prognosis in the old than the inexperienced doctor with his more rational approach. It is by a like scrutiny, by taking into account the observation of others, and by not being too scientific that you will avoid major blunders in prognosis.

This general observation does not take the place of routine examination, for the difficulty in getting a history, and the insidious way in which grave conditions can develop in the old without symptoms, mean that every system must be examined. The difficulty of getting the clothes off the old person

makes a cursory examination tempting, but unless this is insisted on mistakes will occur; skin sepsis, strangulated hernias, lobar consolidation of the lung and obvious evidences of growth, both primary and secondary, are missed and missed not infrequently, by giving way to the attitude of relative or nurse that the old body will get chilled. The examination of the old should be thorough rather than meticulous; for example, it is essential to know whether each of the four limbs can be moved where it may be unnecessary to spend long with pin, cotton-wool and tuning-fork. The old do not respond to infection by a rise in temperature in the dramatic way that the child does, nor in the way that we are accustomed to in the adult. In fact, the temperature in infection may not rise at all or only terminally, and an unexplained change in pulse rate or respiration is often a more reliable sign of infection. The skin temperature of the old tends to be lower than earlier in life owing to their poor peripheral circulation but the mouth and rectal temperatures are reliable provided that the thermometer is left in position for longer than the time advertised on the instrument. Trevor Howell found in Chelsea Pensioners that with increasing age the temperature tended to be lower, and that 95° F. or below was not infrequent among the sick and infirm. In such people a reading of 98 may sometimes be regarded as a raised temperature and a rise above that figure is of more importance and significance than in the young and in active adults.

DIAGNOSIS.

As you will have already gathered from the preceding remarks, accurate diagnosis in the aged is more difficult than in the more florid reaction to disease that obtains in the adult. It is true of course that there is less need for an accurate diagnosis, as treatment is less often able to effect a cure and is often directed to symptoms alone. Nor is there the same urgency, for acute infections are less common than in the young, cancer is less to be feared than in the middle aged, and the whole aspect of disease is one of chronic infection, degenerative changes, and ischæmic processes.

One reason that accurate diagnosis is so difficult in the old is the absence of general reaction of the body to disease of any part. You will have seen how in children there is a very dramatic and widespread reaction of the body to disease of one organ or impairment of one function; thus a urinary infection which in the adult causes fairly localised symptoms and signs will in the child cause a much more widespread illness with convulsions, severe fever and prostration and you are familiar with the surprising widespread effects of such a local irritation as the cutting of a tooth, a tight foreskin, or a fissure in the anus. In the old the very opposite obtains and there may be gross disease of one organ or impairment of one bodily function with no general reaction. Old people are often quite unaware that they are ill because of this lack of general reaction and in addition the dulling of the nervous system makes local symptoms less apparent.

Nor is one justified in satisfying curiosity and attempting to make an accurate diagnosis by investigations which disturb the patient unduly. Only if the institution of rational and helpful treatment depends on such exactitude is such interference justified. As an example, to subject an old person to the ordeal of an alimentary X-ray to determine the site of a growth, when surgery is not contemplated, is cruel, meddlesome, and bad medicine. The aged are too often aware that radical cure is impossible, nor do they expect it, and merely seek relief from their symptoms; and though they are remarkably tolerant of misplaced enthusiasm and academic accuracy, one must not abuse

their patience. I remember well an old man, and he was not so very old, who came up to the Front Surgery with a varicose ulcer and was found to have bilateral swellings in his loins; and I remember also his polite question on the death-bed, to which the investigations of his urinary tract had brought him, as to when the treatment of his leg was to begin.

These warnings of the difficulties and dangers of making an accurate diagnosis are not of course an encouragement to mental laziness for you can often come to a right conclusion in a most satisfying way by clinical methods alone and with no discomfort to the patient.

(To be concluded)

R. D. Gillespie, M.D., F.R.C.P.

1897—1945

ON Tuesday, July 8th, Dr. Thomas Jones, C.H., Chairman of the York Clinic Council, unveiled a bronze bust of the late Dr. Gillespie in the Entrance Hall of the Clinic. Before doing so, he paid the following tribute to his memory :—

" All his friends knew as the war drew to its close that Gillespie had been spending himself freely and that he was tired. That was the history of many others who gave themselves without stint in the national effort. But none the less when his death came it came as a shock and we all knew at once that something significant had happened which would make a big difference to Guy's and to us his friends. None of us could count two of his sort in our circle and when he went his place could not be filled. It is still empty.

Robert Dick Gillespie came of a simple God-fearing Scottish family in which integrity of character ranked as not less important than material success. He accepted the virtuous life of his parents and the exacting standards of his teachers as the moral and intellectual basis of all his work. Throughout his life he remained true to these ideals —the practice of virtue and the pursuit of truth.

He was educated in Glasgow and completed his medical course in that city, qualifying M.B., Ch.B. in 1920, and proceeding to M.D. in 1924 with honours and the gold medal. After an early interest in physiology, Gillespie turned to the study of mental disorder. He obtained his D.P.M. in 1922 after a period

at the Royal Hospital, Glasgow, and then joined the celebrated department in this subject at Johns Hopkins Hospital, Baltimore, where he was assistant resident psychiatrist and instructor in psychiatry.

Returning to England in 1925 he served as assistant physician to the Cassel Hospital for Functional Nervous Diseases and held a research studentship in mental pathology at Cambridge. I have taken these facts and dates from *The Times* obituary notice. His intellectual gifts were such that he was made Physician in Psychological Medicine at Guy's at a remarkably young age. In 1933 he published 'The Mind in Daily Life' and followed it with 'The Textbook of Psychiatry' of which he was joint author with Professor D. K. Henderson, of Edinburgh. This standard book has found favour on both sides of the Atlantic. He was elected F.R.C.P. in 1934; before he was forty he was an examiner and consultant to various institutions.

Gillespie reflects in his career the progress of psychological medicine from the stage where ignorance and prejudice led to the isolation of patients as loathsome victims to be shunned to the stage where mental illness is regarded as a modifiable symptom of maladjustment, a condition where the patient, handicapped by some constitutional defect, is incapable of competing with the strains and stresses pressing upon him.

He began early to interest himself in the growing child. He recognised not only the importance of unfavourable material conditions, malnutrition and the deficiency diseases, but he laid stress on the importance of the absence of affection, of emotional starvation. As a result of all these reflections he pioneered the Child Guidance Clinic attached to Guy's.

When war broke out in 1939 he became psychiatrist to the Royal Air Force. Here the problem was to prevent airmen being unwisely exposed to risks and strains which would lead to breakdowns, whereas if properly wedded to the right kind and degree of responsibility and danger they would emerge triumphant. The task of maintaining the morale of the air crews at a high level was most exacting and exhausting.

In recent years advanced methods of electrical treatment have proved beneficial in certain brain diseases. Gillespie's attitude was that no matter how much was done by means of these mechanical aids the mind itself was more and other than a machine. He never lost sight of this and perhaps his greatest contribution was not only his ability to pass judgment on all the factors involved but to give of himself when the machine failed.

So much for the academic, technical and professional aspect of his career.

His intellectual attainments alone—great and genuine as they were—could never have given him the special characteristic which made him so effective as a physician and lovable as a man. I mean the healing quality of his presence. No patient, colleague or layman could come into contact with Gillespie and not feel soothed, refreshed, calmed, strengthened.

Reduced to its simplest, this healing quality was an ability to love. Gillespie approached everyone, the great and successful or the weak and unfortunate, with an affectionate attitude. He saw them not as *who* they were but as *what* they were, as human beings, as *fellow* human beings. He was not impeded from loving others by fear, jealousy, desire for power or any other manifestation of what is commonly called egotism.

Had Gillespie known nothing of psychological medicine, his goodness, gentleness and sensibility—but most especially his goodness—would have made

him a healer of the human soul, a person who gave others confidence in themselves, and confidence in life itself.

How very rarely does one see his qualities combined! How unusual to find childlike innocence and great intelligence together; strength and tranquillity; energy and patience; a vivid imagination and simple integrity; pre-occupation with the problems of others and extreme sensitiveness. And how pure were his qualities. His innocence was 'unspotted of the world,' his integrity absolute, his tranquillity unfeigned, his unselfishness not compromised by any indulgence.

Nor did Gillespie's qualities end with those that make a saintly character and a scholarly mind. He had as well artistic sensibilities. He was deeply affected by architecture; could become entirely absorbed by the charm of trees and fields; loved theatre and books; and had the gentlest and most refined sense of humour. His command of language and gift of exposition were exceptional.

He had many difficulties in his life and, being more sensitive than most of us, found the pains of ill-health an especially severe strain. But at no moment of his life, no matter how burdened he might be, did he lose in the slightest degree his qualities of greatness. He was never self-pitying, reproachful, or little.

The head which we are unveiling to-day is a portrait made in the last years of his life by an artist with whom he formed a close friendship, Siegfried Charoux. It will remind all who have the privilege to carry on his work, or the benefit of being treated here, that this clinic was built out of respect for an exceptionally fine man, who applied his great intelligence and talents to one purpose only—that of healing. The head itself tells you much of the man—the great dome and finely shaped features, the full mouth and sensitive eyes, and that look of calm modesty by which his handsome face was made gracious. Those who knew him will always look upon this head with deep affection, and succeeding generations will see the countenance of a man who devoted his whole life to relieving the sufferings of others, with love, enlightenment and success.

I esteem it a great honour on behalf of the York Trust to unveil this commemorative tablet and this bust of a great, good and gentle physician."

Having unveiled the bust, Dr. Jones called on the Superintendent. Professor Johnston said:—

"I remember very vividly the meeting of the Selection Committee at which it was decided to recommend Gillespie to the Court of Governors of the Hospital as our Physician for Psychological Medicine, in succession to the late Sir Maurice Craig. I remember, too, the words of the late Sir Farquhar Buzzard, who was our external expert on that occasion. There was another, older and more experienced candidate in the field and at first it was uncertain which of the two would command the most support, but Buzzard had been so impressed by the brilliant promise that Gillespie's early work had revealed that he urged very strongly that we should 'take the gamble of appointing the younger man' and he swayed the Committee. Gillespie was then only 28, but the subsequent story of his career testified abundantly to the soundness of Buzzard's judgment.

As fellow-Scots, Gillespie and I soon became firm friends and I can remember well his coming to me some ten years ago to discuss the proffered

gift of the York Clinic. From the outset he stressed the importance to Medicine and to Guy's of this opportunity of linking such a clinic with a Teaching Hospital, and, although the Court was at first somewhat dubious about accepting the gift on account of the financial position of the Hospital at that time, Gillespie's arguments carried conviction and the Clinic came into being.

We who knew him well regarded him with sincere affection, for, in addition to vision and understanding, he had kindness and an incredible modesty that almost amounted to humility. He had the interests of Guy's and of his own specialty warmly at heart, and no man was ever prompted by more altruistic motives. His work, so well and surely begun and holding out still further promise for the future, ended all too soon.

I think you will agree that the bust is a worthy memorial and that it is in its proper place here, in the entrance hall to the Clinic in which he took so much pride."

Correspondence

Scientific Approach to Surgery

SIR,—Mr. Nils Eckhoff in his admirable article on the "Scientific Approach to Surgery in America" in the last issue of the *Gazette* remarks that "either we in England have not paid enough attention to the significance of biochemistry in medicine, or the Americans have stressed it too much."

Unless I am mistaken, the support of Mr. Eckhoff's article in reference to this question is that we in this country are much behind the Americans in the systematic, as distinct from the casual, application of laboratory methods in medicine. I believe this to be generally, though, it is only fair to point out, not entirely true. It was scarcely necessary for Mr. Eckhoff to travel three thousand miles to discover the value of the "scientific" approach to medicine. It has long been fully appreciated in many centres in this country. Had he, for example, visited the Nephritis Clinic at Guy's at any time since its unofficial inception in 1921 until the outbreak of war in 1939, he would have found all the relevant biochemical methods he mentions and not a few others in routine use. Indeed, it is not possible to practise nephrology seriously without such aids or with any other approach. Guy's may therefore claim to have been early in the field in the systematic application of methods of precision to the problems of diagnosis, treatment, assessment of progress and after-care in at least one branch of medicine. A similar approach has doubtless long been customary in other special branches of medicine in many centres in this country.

What Mr. Eckhoff does not tell us, and what it would be of great interest to know, is whether the systematic use of such methods is more widespread in America than here.

However this may be, Mr. Eckhoff is certainly to be congratulated on a most valuable paper that should do much to stimulate a more general adoption of what he terms the scientific approach in the practice of medicine and surgery in this country.

I am, etc.,

London, W.1. A. A. OSMAN.

Hospital Illustrators

SIR,—In a recent editorial, in congratulating Miss Treadgold on her appointment as Hospital Illustrator, you stated that this was a new appointment. This is not strictly true, the first artist was appointed to the Hospital soon after the founding of the Medical School, circa 1780; he was Mr. C. J. Canton, and illustrated Bright's "Medical Reports" and the first few volumes of the Guy's Hospital Reports. After his death in 1840, William Hurst was appointed and drawings of his appear in the majority of Guy's Hospital Reports until his death in 1889. Others who have illustrated for the Hospital, but apparently not on a full-time basis, and whose illustrations are still in the Gordon Museum are, William Monxon (c. 1869), J. L. Tupper (c. 1879), B. G. Gowan (c. 1883), Toogood Hill (1890's), M.I.S. (1900's), Mabel Green (1911), A. W. Head (1913), and W. Thornton Shields (1920–40).

I am, etc.,

Guy's Hospital, S.E.1. IAN SCOTT.

Sport

CRICKET

GUY'S *v.* ST. ANNE'S.

(*Played at Virginia Water on June 25th.*)

Result: Guy's won by 9 wickets.

In perfect June weather Guy's visited St. Anne's for the first time since the outbreak of the war. The home side won the toss and decided to bat on a slow wicket.

Russell and O'Driscoll bowled steadily and accurately and at lunch St. Anne's had scored 57 for three wickets. Shortly after the interval Guy's got two valuable wickets in Clarke (27) and Davies (38), and the remaining batsmen offered little resistance, the side being dismissed for a total of 140 runs.

Holmes and Whittaker opened the Hospital's innings and quickly took the score to 50 when Whittaker was caught in attempting a hook stroke. This brought in Williams to join Holmes; runs came freely, Guy's passing their opponents total with the loss of only one wicket. Holmes continued to bat soundly and complete a chanceless century.

Scores: St. Anne's 140 (Russell 4—29). Guy's 235—3 wkts. (Holmes 101 not out, Williams 49).

SEMI-FINAL HOSPITAL CRICKET CUP

GUY'S *v.* ST. MARY'S.

(*Played at H.O.P. on June 28th*, 1947.)

Result: Draw.

In this game Guy's won the toss and put St. Mary's in to bat on a damp wicket. During the first hour's play only 28 runs were scored, due to accurate bowling and at the luncheon interval St. Mary's had scored 54 for three wickets.

After thirty minutes play in the afternoon, rain fell very heavily and the wicket became easier. St. Mary's batting for nearly four hours declared their innings closed with the total of 196—9 wickets.

Guy's soon lost two wickets for 21 runs and were in an awkward situation until Holmes and Nicholson took the score to 68, when Nicholson was dismissed for 23. Another reverse quickly followed—Graham being well caught in the slips. The score, 69 for four wickets.

The next wicket fell at 92, Holmes was caught after scoring 43 in 2¼ hours. A useful innings on a difficult wicket. During the remaining time Guy's scored a total of 124 for six wickets, the match ending in a draw.

Scores: St. Mary's 196—9 wkts. (dec.). Guy's: 124—6 wkts. (Holmes 43, Nicholson 23).

Guy's Team: J. D. Williams (Capt.), R. G. Nicholson, E. W. Graham, A. M. Platt, P. S. Holmes, H. M. O'Driscoll, M. C. Gilbert, P. S. Russell, J. F. Woodford, A. H. Whittaker, K. B. Bender.

GUY'S *v.* BOGNOR REGIS C.C.

(*Played at Bognor on June 29th*, 1947.)

Guy's: 168 (Williams 91, Russell 20).

Bognor Regis: 98 (O'Driscoll 4—14).

Result: Guy's won by 70 runs.

GUY'S *v.* EALING DEAN.

(*Played at Perivale on July 5th*, 1947.)

Guy's: 142 (Curtiss 41, Billingham 32, Woodford 32).

Ealing Dean: 154—8 wkts.

Result: Ealing Dean won by 3 wkts.

GUY'S *v.* STREATHAM.

(*Played at H.O.P. on July 6th*, 1947.)

Streatham: 169 (Nicholson 5—29).

Guy's: 150—5 wkts. (Williams 61, Graham 31).

Match drawn.

House Appointments

AUGUST 1ST TO OCTOBER 31ST, 1947.

GUY'S.

ASSISTANT HOUSE SURGEONS.

To Messrs. Slesinger and Brock	Mr. N. B. Finter	*New Appointments.*
„ Sir H. Ogilvie and Mr. Atkins	Mr. B. V. McEvedy	
„ Messrs. Massie and Wass	Mr. A. G. Parks	
„ Messrs. Eckhoff and Blackburn	Mr. J. L. Moffatt	

OUT-PATIENT OFFICERS.

Mr. J. M. Hall
Mr. T. E. Oppé
Mr. J. M. Holmes
Mr. J. G. Stebbing
Reappointments.

HOUSE PHYSICIANS.

To Sir J. Conybeare and Dr. Hardwick	Mr. L. J. Evered	*Reappointments.*
	Mr. G. J. Hamilton	
„ Drs. Campbell and Hampson	J. Hart*	*New Appointments.*
	Mr. A. W. Banks*	
„ Drs. Douthwaite and Mann	Mr. K. M. Gough*	*New Appointments.*
	Mr. A. B. Lee*	
„ Drs. Boland and Baker	T. W. Renton*	*Reappointment.*
	Mr. F. R. S. Knight*	*New Appointment.*

HOUSE SURGEONS.

To Messrs. Slesinger and Brock	Mr. I. D. Henderson*	*Reappointment.*
„ Sir H. Ogilvie and Mr. Atkins	Mr. G. W. Garland*	*New Appointment.*
„ Messrs. Massie and Wass	Mr. D. J. Tibbs*	*Reappointment.*
„ Messrs. Eckhoff and Blackburn	Mr. R. N. Ticehurst*	*Reappointment.*

RESIDENT OBSTETRICIANS.

August 1st to October 31st, 1947	Mr. J. Crossley	*Reappointments.*
September 1st to November 30th, 1947	Mr. G. M. Evans*	
October 1st to December 31st, 1947	Mr. M. D. Keates*	

CHILDREN'S HOUSE OFFICERS.

Mr. S. A. Marsh* *Reappointment.*
Mr. J. Morton Palmer* *New Appointment.*

* Ex-Service Medical Officer.

NEUROLOGICAL HOUSE PHYSICIAN.

Mr. H. Goldschmidt. *Reappointment.*

THROAT AND EAR HOUSE SURGEON.

Mr. M. B. Conran. *Reappointment*

DERMATOLOGICAL HOUSE PHYSICIAN.

Mr. M. A. Shellim* (Non-Resident) *Reappointment.*

OPHTHALMIC HOUSE SURGEON.

Mr. P. L. Blaxter* (Non-Resident) *New Appointment.*

FRACTURE HOUSE SURGEON.

No appointment made.

BACK SURGERY HOUSE SURGEON.

No appointment made.

ORPINGTON.

EAR AND THROAT HOUSE SURGEON.	Mr. J. D. Trethowan*	*Reappointment.*
ORTHOPÆDIC HOUSE SURGEON (combined with House Physician to Dr. Campbell.)	Mr. W. E. R. Alderman*	*New Appointment.*

SOUTHERN.

HOUSE SURGEON.	Mr. M. S. Kay	*New Appointment.*

JOYCE GREEN.

HOUSE SURGEON TO MR. TURNER AND EAR, NOSE AND THROAT HOUSE SURGEON.	Mr. W. H. Barker	*New Appointment.*
NEUROSURGICAL HOUSE SURGEON.	Mr. A. F. Crick	*New Appointment.*

PEMBURY.

HOUSE SURGEONS.	Mr. R. A. Griffiths	*New Appointments.*
	Mr. J. H. B. Yule	

* Ex-Service Medical Officer.

Junior Staff Appointments

MEDICAL SCHOOL

Assistant to the Director of the Department of Medicine.
R. Kauntze, M.D., as from a date to be arranged until 30th September, 1949.

Assistant to the Director of the Department of Surgery.
C. P. Nicholas, F.R.C.S., as from 1st September, 1947, until 30th September, 1949.

Tutor in Charge of the Preliminary Clinical Period Class.
J. R. Forbes, M.D., for one year as from 16th October, 1947.

Medical Registrar.
C. S. Darke, M.D., for six months as from 1st October, 1947.
J. C. Houston, M.D., for one year as from 1st October, 1947.
K. S. MacLean, M.R.C.P., for one year as from 1st October, 1947.
S. H. Llewellyn Smith, M.R.C.P., for one year as from 1st October, 1947.

Surgical Registrar.
F. N. Glover, M.S., as from 1st September, 1947, until 30th September, 1949.
R. E. Horton, F.R.C.S., for two years as from 1st October, 1947.
B. G. A. Lilwall, F.R.C.S., for one year as from 1st October, 1947.

Clinical Assistant and Registrar in the Ophthalmological Department.
P. A. Gardiner, M.B., B.S., for one year as from 1st October, 1947.
J. C. G. Moore, M.B., B.Ch., as from 1st July, 1947, until 30th September, 1948.

Department of Clinical Pathology.
Assistant to Director.
E. H. Koerner, D.M., for one year as from 1st October, 1947.

Assistant Clinical Pathologists.
J. B. Foote, M.B., B.Ch., for one year as from 1st October, 1947.
F. L. Jackson, M.B., B.S., for one year as from 1st October, 1947.
B. G. Stephens, M.R.C.S., L.R.C.P., for one year as from 1st October, 1947.

Registrar to the Dermatological Department.
E. J. Moynahan, M.R.C.P., for two years as from 1st October, 1947.

Clinical Assistant in the Department of Diagnostic Radiology.
A. C. Glendinning, M.B., B.Ch., for one year as from 1st October, 1947.
J. M. Weston Wells, M.R.C.S., L.R.C.P., for one year as from 1st October, 1947.

Anatomy Department.
Assistant Lecturers.
G. D. Channell, M.B., B.S., for one year as from 1st October, 1947.
G. P. A. Sechiari, M.R.C.S., L.R.C.P., for one year as from 1st October, 1947.
Demonstrators.
H. P. Guerrier, M.B., B.S., for one year as from 1st October, 1947.
I. D. Henderson, M.B., B.S., for one year as from 1st October, 1947.

Chief Clinical Assistant and Registrar to the Ear, Nose and Throat Department.
C. N. d'Eastes, L.M.S.S.A., as from 1st July, 1947, until 30th September, 1948.
K. L. Wilson, M.R.C.S., L.R.C.P., for one year as from 1st October, 1947.

Radium Registrar and Chief Clinical Assistant to the Radiotherapy Department.
A. B. Wayte, M.R.C.S., L.R.C.P., for one year as from 1st October, 1947.

Chief Clinical Assistant and Registrar in the Department of Psychological Medicine.
R. L. Moody, M.B., B.S., for one year as from 1st October, 1947.

Department of Morbid Anatomy and Histology.
Assistant Lecturer (Griffiths).
P. A. I. Gorer, M.R.C.S., L.R.C.P., for one year as from 1st October, 1947.
Gull Student.
J. O. Laws, M.B., B.Ch., for one year as from 1st October, 1947.
Demonstrators.
K. J. Randall, M.B., B.S., for one year as from 1st October, 1947.
R. J. W. Rees, M.B., B.S., for one year as from 1st October, 1947.

Biology Department.
Assistant Lecturer.
B. J. Rickard, B.Sc., for one year as from 1st October, 1947.
Demonstrators.
E. H. Batten, B.Sc., for one year as from 1st October, 1947.
E. Cameron, Ph.D. (Part-time), for one year as from 1st October, 1947.

Physics Department.
Assistant Lecturer.
W. J. R. Calvert, M.A., for one year as from 1st October, 1947.
The re-appointment of A. H. Walker, Ph.D., was left over until the results of the 2nd M.B. are known.
Demonstrators.
C. W. Wilson, Ph.D. (Part-time), for one year as from 1st October, 1947.

Chemistry Department.
Assistant Lecturers.
M. E. Foss, B.Sc., for one year as from 1st October, 1947.
W. L. Gent, B.Sc., for one year as from 1st October, 1947.
Demonstrators.
P. R. Rowland, B.Sc., for one year as from 1st October, 1947.

Physiology Department.
Assistant Lecturer (and Anderson Demonstrator of Clinical Chemistry).
Miss A. Shore, B.Sc., for five years as from 1st October, 1947.

Chief Clinical Assistant and Registrar to the Department for Nervous Diseases.
M. J. Parsonage, M.R.C.P., for one year as from 1st October, 1947.

Hospital Information, etc.

NOTICES

THE 1921 INNOMINATE CLUB.

The Annual Dinner was held on May 30th, 1947, at the Trocadero, with J. H. M. Lloyd in the Chair, thirty-two other members present. As usual an informal and most pleasant evening was had by all. F. Marsh was elected Chairman for 1948.

As a point of interest to old Guy's men, the Innominate Club is one of the few dinner clubs founded for men who were at Guy's immediately after the 1914–18 war. Any Guy's man who qualified before 1927 is eligible for membership.

G. T. HANKEY,
Hon. Sec.

89, Harley St., London, W.1.

G.H.R.F.C.

The Annual Rugger Dance will be held at The Hyde Park Hotel, Knightsbridge, on Wednesday, October 29th. Dancing 9—2. Bar. Tickets from Hon. Secretary, Rugger Dance, Guy's Hospital, S.E.1. Price 25*s.* (single), 50*s.* (double), buffet inclusive.

GUY'S HOSPITAL MEDICAL SCHOOL.

Applications are invited for the post of Lecturer in Pharmacology. Candidates should be medically qualified. Commencing salary not less than £650 per annum with superannuation and family allowance. Forms of application may be obtained from the Dean, Guy's Hospital Medical School, S.E.1, to whom applications with the names of three referees should be forwarded not later than 15th August, 1947. The appointment will date from 1st October, 1947, and will be for two years in the first instance.

Applications are invited for the appointment of Demonstrator in Physiology Department as from 1st October, 1947. Salary £550 per annum plus superannuation and family allowance.

Forms of application, copies obtainable from the Medical School Office, should be lodged with the Dean not later than 22*nd August*, 1947.

NURSING STAFF.

There are vacancies for Staff Nurses in the Wards, Theatres, Nuffield House and other Departments of the Hospital. Senior post vacancies occur from time to time. Guy's trainees who are interested should apply to The Matron, Guy's Hospital, S.E.1.

PASS LIST

UNIVERSITY OF OXFORD.

Trinity Term, 1947.

Medicine, Surgery and Midwifery.

R. Harvard Davis	B. V. McEvedy
R. A. Griffiths	A. G. Parks
M. S. Kay	J. H. B. Yule
C. C. Kennedy	

CONJOINT BOARD.

July, 1947.

Pathology.

K. M. Citron	J. V. Kilby
H. M. C. O'Driscoll	A. G. McCallum

Medicine.

G. D. Banyard	R. H. N. Long
*S. J. Harris	*D. M. Rahilly
A. L. Jeanes	R. L. Timms
*J. Lederer	

Surgery.

M. D. M. Bowen	J. B. Morrison
*J. K. G. Grieves	D. J. R. Snow
P. R. Harben	*J. Southgate
M. G. Kaye	D. B. Sugden
A. R. Merrill	

Midwifery.

M. D. M. Bowen	H. R. C. Riches
P. S. Carton-Kelly	P. R. M. Scales
J. R. Greaves	D. J. R. Snow
*J. K. G. Grieves	*J. Southgate
D. F. N. Harrison	R. L. Timms
J. V. Kilby	A. J. De Villiers
*D. M. Rahilly	

* Have completed the examination.

ROYAL COLLEGE OF SURGEONS.

Fellows in Dental Surgery.

Included in the list of dental surgeons invited to become Fellows in Dental Surgery are the names of the following Guy's men:

W. Kelsey Fry, C.B.E., M.C.
F. S. Warner

UNIVERSITY OF LONDON.

EXAMINATION FOR THE ACADEMIC POST-GRADUATE DIPLOMA IN MEDICAL RADIOLOGY.

July, 1947.
P. M. Davies

SCHOLARSHIPS IN ARTS AND SCIENCE.

The following Awards have been made for 1947 :—

MEDICAL SCHOOL.

Entrance Scholarship in Science.—No award.
Entrance Scholarship in Arts.—
Scholarship.—No award.
Exhibition to the value of £50.—John Leslie Turk (Malvern College).

DENTAL SCHOOL.

Entrance Scholarship in Science, of the value of £40 per annum for four years, to Richard Victor Seymour Muscat (Isleworth County School).
Entrance Scholarship in Arts.—No award.

APPOINTMENT

D. Stafford-Clarke has been appointed to a Nuffield Fellowship in Psychological Medicine for three years from October 1st, 1947.

ORDER OF THE HOSPITAL OF ST. JOHN OF JERUSALEM.

Promotion and Appointment.

Officers: R. C. May, O.B.E., M.C., M.R.C.S.
H. C. Davies, M.R.C.S.

BIRTHS

COUNSELL.—On July 15th, 1947, at Nuffield House, to Jessie, wife of Brian Counsell—a daughter.

WEST.—On June 30th, 1947, at Finlay House, Winchester, to Mary, wife of Roger West—a son (Andrew John).

MARRIAGES

NEILD—SURRIDGE.—On July 16th, 1947, in London, William Cecil Neild, B.A., M.C., of Kelle, Little Leighs, Chelmsford, to Nonie Surridge, S.R.N., D.N., of Inworta Hall, Kelvedon, Essex.

DEATHS

FRANKS.—On July 17th, 1947, Ronald Michael Jack Franks, of Kensington Park Gardens, aged 31 years.

HERBERT.—On July 24th, 1947, Arthur Henry, Herbert, L.D.S., R.C.S., Eng., of Essendene, Chobham Road, Woking, Surrey.

Eds. {D.H.F. H.A.R.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

LIFE has always been, especially to philosophers, a series of problems. With the country in its present state of post-war complications the number of difficulties facing the citizen in his quest for daily bread is greatly increased, and life has become a sort of nightmarish obstacle race possessing an evergrowing number of pitfalls.

There is the much vexed question of food, the inexplicable chaos of the car market, the unintelligible Governmental labour licensing system, and all the hundred other fantastic items on this present programme of national behaviour.

The doctor's wife is beset by all the usual worries that face any housewife, but there is one problem in particular which seems designed to cause more than the average number of grey hairs per week, namely, that almost insuperable difficulty, glibly referred to as—the domestic problem.

To fulfil successfully her duties these days the practitioner's wife must, of necessity, possess the unique quality of being able to appear in two entirely different places at the same time. She must be able to stand in a queue for fish and, at the same moment, be prepared to answer the telephone or obey the slightest whim of that most merciless of inventions—the front-door bell. Naturally she must cook the dinner, clean the house, bath the children and perform all those other delightful pastimes that help to overfill a housewife's day, but also, at a moment's notice, she must become a polite receptionist and a sympathetic listener. She must never cease to be meticulous in her dress for should she attire herself shabbily, or even hastily, it will be noticed and remarked upon and she will feel that she has let down her husband's reputation as well as her own. She must retain that equable temperament that the patients expect of her, in spite of the fact that deep down in her innermost self she is probably fighting that almost irrepressible temptation to batter Mrs. Jones's children to death or let fly a volley of abuse at the neurotic old gas-bag at the other end of the telephone line whose empty and long-winded prattle is successfully ruining the lunch.

So few people are able to obtain, let alone afford, domestic servants these days that those members of the public who really need such help are naturally wondering what has happened to make this domestic problem so grave and, even more important, what is to be done about it.

Apart from such factors as the war, conscription into national service, and increased wages in other occupations, the improved and more widespread system of general and specialised education has undoubtedly a great deal to do with it. Having told *everybody* that he or she carries a field-marshal's (or field-commandant's) baton in their knapsack and, furthermore, educated them to become field-marshals, it is little wonder that the more menial jobs in life, such as domestic service, are scorned. Instead of having a steady

source of ignorant flunkeys from which to choose, we are presented with a band of learned revolutionaries who quote Marxism to us and tell us what Jean Jacques Rousseau (whoever he was) said in his "Contrat Social" (whatever that was). Instead of having straw behind their ears, they have pencils, and the only sickles they have ever seen are on flags. Regretfully we must admit that, with the advent of this enlightened age, the good old serf has disappeared from our land, and those who might have become faithful old family retainers are in danger of becoming Prime Ministers or Chancellors of the Exchequer.

Thus we must abandon all hope of being able to employ in domestic service any person who has been or can be educated. We must look in another direction for our maids and daily helps, namely, to that happy band of humanity who, by reason of some intellectural flaw in their make-up, are unable to benefit from books—the mentally defectives. Instead of being the proud employers of intelligent helpers, we shall be obliged to content ourselves with becoming the grateful keepers of affectionate mongols, or trustworthy cretins. In this last particular it is obvious that if the servant problem is to be solved as soon as possible, we must not be too eager to dispense our Thyroid extracts. Doubtless the State Medical Service will have foreseen this detail and have already prepared the necessary forms (Limitation of Supplies, Resident Cretins Act 194—.).

Like all new schemes this idea may appear a trifle bizarre at first, but this project does possess definite advantages. For example, it will be impossible, or at any rate a waste of time, to lose one's temper over the actions of these servants. It will be redundant, to say the least, for anyone to exclaim, "You're an idiot!" to a maid whose lolling tongue and low brow can do nothing but agree with you wholeheartedly.

Disadvantages may be numerous also, but a well-managed moron can lighten the housewife's load in some measure and, until robots are perfected machines, we can think of no other solution to this urgent quest for the "daily help."

Old Age

A Clinical Lecture given on May 16th by CHARLES BAKER, O.B.E., M.D.

(*Concluded*)

THE DISEASES OF THE OLD.

It is not possible in one clinical lecture to do anything but touch on the various modifications of disease as it affects the aged, but I will mention some of the more common conditions and difficulties that occur in the various systems.

Alimentary System.

One must be very tolerant of dental sepsis, for dirty and loose teeth are never a cause of general disease and hardly ever a cause of dyspepsia in the old. The absence of teeth is more troublesome and more likely to cause indigestion; extractions therefore are seldom indicated, for old people do not take kindly to artificial teeth and often remove them to eat. Dyspepsia is a fairly common symptom either through poor mastication or through an ill-advised diet; some old folk are very naughty in their dietary indiscretions and old ladies particularly are apt to drink too much strong and stewed tea. One must be careful of sudden attacks of "wind" which not infrequently

mask an attack of coronary thrombosis, or are the first indication of a failing heart. Peptic ulcer can be remarkably silent in the old and gastric ulcer in particular is quite common. Hæmatemesis from gastric ulcer is not often seen in the wards of a teaching hospital but is by no means uncommon in practice, or in hospitals under local authority. The wasting, anæmia and cachectic appearance often invite a wrong diagnosis of carcinoma of the stomach, in which severe hæmatemesis rarely occurs. it is astonishing how these cases will respond to treatment with blood transfusion, fluid replacement and early feeding, if it is profferred.

Constipation is the bugbear of old people, particularly the bed-ridden. They are very preoccupied with their digestion and the state of their bowels and it is often their one and abiding interest in life. Many follow the passage of their meals through the length of their alimentary tract, noticing every squeak, spasm, and rumble, are most dismayed if there is any delay in the expected delivery, and regard a failure to obtain a satisfactory stool at the appointed time as a minor tragedy. The constipation of the young or middle aged is usually a dyschezia, the result of bad habits and laziness; here we are right to condemn the use and abuse of purgatives, for they must be re-educated to recover their normal functions. In the old, however, constipation is not the result of laziness. Through lack of teeth or impaired digestion their diet is pappy and lacks roughage; there is a slower passage through the alimentary tract for with increasing age there is loss of normal tone in smooth muscle and reflex action is not so brisk: and there is the additional factor of lack of exercise through an enforced sedentary life. Furthermore, the lack of tone in the abdominal muscles makes it more difficult to evacuate a constipated stool, and the necessary straining is dangerous in that it may provoke a vascular catastrophe. Lubricants, laxatives and the occasional enema are therefore necessary in the old. False diarrhœa may occur due to the retention of hard fæces which become dehydrated to a rock-like consistency, when they can be felt not only in the rectum but by abdominal palpation; the fluid contents of the small intestine are denied access to the dehydrating action of the mucosa of the large intestine and pass through the fæcal rocks like water in a mountain stream, to be voided as a loose motion. This is a not uncommon cause of incontinence and a dirty bed in the old and feeble, the treatment being manual removal of the rectal masses followed by enemata. In the absence of this false diarrhœa, the passage of loose and frequent stools indicates most commonly the late stages of a carcinoma of the large intestine or rectum, which in its early stage easily escapes notice in the habitual constipation of the aged. Have pity on the old with regard to the bed-pan, a reasonable distaste for which is a frequent cause of constipation in the bed patient. It is important to realise that less effort is needed on the part of the patient, and for that matter those looking after him, to slide on to a commode by the bedside rather than to be hoisted on to a bed-pan.

Respiratory System.

The old are remarkably free from the acute infectious diseases of the upper respiratory tract such as the common cold and influenza, and even in the pandemic of influenza of 1918–19 the very old were relatively immune. The two commonest, one might almost say the only important, affections are the acute disease of pneumonia and the more chronic condition of bronchitis and emphysema. Pneumonia has been called the friend of the aged for it gives them their dispatch in a quiet, quick, painless and efficient way, but

this was said before the days of the "sulpha" drugs and penicillin; now, many old people, if promptly treated, may recover to enjoy a few more years of life. I have already stressed the insidious nature of this illness and to impress this important point on your memories I might quote Housman and Dechambie, Physicians in the Salpêtrière in Paris, where the illnesses of the aged were first studied seriously, work which culminated in Charcot's classical Lectures on Senility. In 1836 they wrote: "The old women do not even complain of malaise; no one in the wards, neither guardians, servants or neighbours, perceive any change in their condition. They get up, make their beds, walk about, eat as usual; then they feel a little fatigued, sink upon their beds and expire. This is one of the sudden deaths at the Salpêtrière. The body is opened and we find a great part of the pulmonary parenchyma in a state of suppuration." The slightest hint that all is not well with an old person, particularly if associated with a rise in pulse or respiratory rate, *even in the absence of fever*, must raise the suspicion of a lobar pneumonia and this is more often confirmed by physical examination than in younger people. The slightest suspicion warrants specific therapy if life is to be saved or is worth saving, for with delay, though the pneumonic process may be checked, the sudden death which Housman and Dechambie noted, may carry them off from heart failure. Broncho-pneumonia is less common and less likely to be missed than lobar pneumonia though it may develop insidiously from a habitual bronchitis: it is wise to use penicillin at once and not trust to sulphonamides alone. The use of oxygen by B.L.B. mask or in a tent is invaluable in senile pneumonia.

People with chronic bronchitis often live well beyond their allotted span, though the associated emphysema makes their existence a very restricted one. They must be protected from the vagaries of the weather and if they can survive one winter they will usually last till the next. Perpetually breathless with a permanent cyanotic tinge, they are comforted by their expectorant mixture despite the nihilistic pronouncements of the pharmacologists. Acute exacerbations of bronchitis, particularly if the temperature is raised, should be treated with penicillin by insufflation and by injection, if fatal broncho-pneumonia is to be averted. Bronchial spasm in chronic bronchitis will respond to adrenalin, which is not a dangerous drug, just as will the spasm of asthma. It is imperative to distinguish this from the sudden onset of dyspnœa, particularly if nocturnal, in the patient who has no history of chronic bronchitis: this is the cardiac asthma of left ventricular failure, and morphia, not adrenalin, is the drug to use.

One additional point to remember is that senile phthisis is occasionally hiding under the cloak of chronic bronchitis: it is compatible with reasonably good health, except for the younger members of the family in contact with it, and for them, and not for grandad, the cough may be fatal.

Cardiovascular System.

With increasing years (from childhood to old age) the average level of blood pressure, both systolic and diastolic, rises until between 75 to 80, above which it falls. The reason for this fall is presumably that many with the highest readings in the earlier ages have succumbed to vascular catastrophes, while many of those who remain have a falling blood pressure due to increasing senility and chronic disease. In old age therefore systolic pressures of 160 or over must be considered as normal while the diminished elasticity and increasing rigidity of the arteries causes a wider difference between the

systolic and diastolic levels than in younger people. A high pulse pressure, which in the young and middle aged is usually transient and due to nervousness and apprehension, is a constant and common finding in the old. Though apoplexy and strokes are a frequent occurrence in the aged, a high blood pressure is not the serious finding that it is in younger people and, in most cases, it is a welcome finding. The reason for this is that a high head of pressure is needed to maintain the circulation through the thickened and narrowed arteriosclerotic vessels. The thicker and more tortuous the palpable vessels and the more marked are the retinal changes, the better is it to find a raised blood pressure. You are more likely to find gangrene, heart failure, mental deterioration—all the results of ischæmia due to arteriosclerosis—when the blood pressure is low or within limits which would be considered normal at a younger age. A low blood pressure is usually a bad sign in old age and the falling pressure that is seen with infections, chronic disease or a general failing of vitality, usually indicates that death is approaching and that the old person, like the Guy's patient, is simply fading away. The patient with the high pressure is also fortunate in that he is more likely to retain his bodily and mental functions until heart failure or apoplexy kills him, and is spared the indignity of needing to be cared for by others in a vegetable and lingering existence, " sans everything."

The only important cause of heart disease in the aged is myocardial ischæmia due to coronary artery disease. The essential hypertension that causes strokes and heart failure in middle age has already claimed its victims, and high blood pressure, though it is found, has not the significance *per se* that it has in younger people : similarly, though the effects of rheumatic or syphilitic heart disease are occasionally seen in the very old they do not play a large part in any failure that may be present. Auricular fibrillation is a not infrequent finding and is compatible with a reasonable function of the circulation ; it has not the significance, nor does digitalisation have the same good effect, as in younger people. Particularly in the emphysematous, it may be difficult to estimate the heart size and enlargement is not by itself a great help in prognosis. Murmurs may be striking in their loudness, conduction and roughness and, apart from the curiosity of valvular disease surviving to old age, indicate calcareous deposits in and around the valves. Aortic stenosis from this cause is frequently missed. Triple rhythm is a more important finding than murmurs for it is most often heard in the heart that is failing or labouring. It will be seen therefore that many of the signs that are so important in diagnosis and prognosis in the young and middle age are of less help in the old, and it is the recognition of the symptoms and signs of failure that have most significance. Right-sided heart failure, with its slow onset of congestive changes, is not likely to be neglected but is not as common as you would expect, though it is often the cause of death in the emphysematous. Left ventricular failure, on the other hand, is more sudden in its onset, its manifestations may be missed, and it is the commonest type of heart failure in the old. The onset of attacks of breathlessness at rest, most often at night ; changes of respiratory rhythm, particularly of Cheyne-Stokes breathing ; and the sudden onset of " bronchitis " and pulmonary œdema mean left ventricular failure and are of the gravest import. Pulmonary embolism is a cause of sudden death in old people.

Angina is not very common in old age despite the fact that ischæmia is the basis of the pathology of heart disease. Coronary thrombosis is frequent

and often silent and a sudden deterioration of health without pain may be the only indication that this has occurred, though the electrocardiographic changes are emphatic. Another indication of the failing heart in the old is an increasing weariness with mental deterioration and this seems to be more common in those with a low and falling blood pressure. One must also be on one's guard following seeming recovery from an acute illness if the blood pressure remains low. Digitalis is of little value in this " toxic myocarditis " and the most helpful drug which may avert death, though usually it only postpones it, is Nikethamide (Coramine).

Diabetes in the aged is seldom severe, and as the triad of wasting, thirst and polyuria are frequently absent it is found by routine examination of the urine or by its attendant conditions of peripheral neuritis, gangrene, or cataract and retinal changes. It can in most cases be controlled by diet alone, and insulin should be avoided if possible owing to the obvious difficulty of arranging for it to be given and the danger of hypoglycæmic attacks to the senile heart muscle.

Central Nervous System.

The commonest conditions which affect the brain and nervous system are strokes from cerebral hæmorrhage and thrombosis, and senile dementia from progressive cerebral ischæmia and arteriosclerosis. Strokes are not always fatal, and many old people survive several minor episodes without loss of consciousness. While it is wise to assume that life is precarious when a major attack with unconsciousness has been survived, the limitation of activity imposed by the hemiplegic state after the first attack may postpone the second. The picture of senile dementia may vary very greatly, the commonest being a progressive dimming of awareness, loss of memory and, especially at night, confusion of thought; with this there is a steady diminution of activity until the patient finally becomes bed-ridden, helpless, and incontinent. Bizarre behaviour may occur, often associated with the three most important actions of the day—eating, micturition and defæcation. Conventional restraints are cast off, the language may be rich and Tudor, and they don't always " babble of green fields." Delusions and hallucinations are not uncommon; these may be harmless but when they take the form of delusions of persecution they may cause violent actions directed against others. Fortunately the feebleness of body renders the agressiveness of mind less dangerous, and depressed states are more common than manic states where the restlessness and excitement may be extreme; the increased activity, or more commonly the sedatives needed to control such violent outbursts, may be fatal. Senile dementia in any of its forms demands institutional treatment.

Paralysis Agitans is common in the aged; the rhythmic tremor seen in the nodding head, rodent-like movements of the jaw and dice-shaking movement of the hands, though they may interfere with the accuracy of eating, cause little disability compared with the other distressing symptom of rigidity, which may convert the unfortunate sufferer into a helpless, mummified state. The mask-like face and inability to articulate often suggest a mental deterioration which is not present, and the patient is deprived of contact with and the sympathy of others, which his unimpaired cerebration craves. The realisation of this and any measures to combat this isolation—the wireless is a great help—evoke a gratitude and warmth which the immobility of face and voice renders the patient pathetically unable to express. It is worth trying the effect of large doses of hyoscine combined with pilocarpine but I have been generally disappointed in the results.

Conditions affecting locomotion.

" Rheumatism " in the aged is seldom due to infective causes and active rheumatoid arthritis is rare, though its aftermath of crippled joints with secondary osteoarthritic changes is common. The old are particularly liable to " strains " and to " fibrositis " which are usually a combination of impaired circulation in the connective tissues and osteoarthritis in the joints. They often respond well to physical measures and these should not be denied, for apart from the relief of pain, nothing is more dangerous in the old than immobility. Anything that can be done to keep old persons on their feet should be done, for once they take to their beds, they are apt to " seize up " and may quickly succumb to the chronic infections, mental deterioration, and pressure sores of immobility. It must be remembered that osteoarthritis which is so common as the result of previous trauma, previous arthritis, and occupational stresses, is *the* arthritis of old age. It is a degenerative condition and no cure can be expected. The old understand this if it is explained to them, but neglect of this may cause them much heart-burning and expense in their attempt to find one. Relief from their pain and disability can be offered them even if fixation of a joint with arthrodesis is needed. Focal sepsis plays no part in the arthritis of the aged, and a search for it and eradication of suspected sources are a waste of time and unjustifiable interference. Gout is seen in the aged but the acute painful attacks are usually in the past though the crippling from chalk stones and secondary osteoarthritic changes may be extreme. Paget's Disease seldom causes symptoms. Indolent ulcers from past attacks of phlebitis and from varicose veins should be energetically treated during a period of enforced rest so that activity can be regained. The outlook with gangrene is very poor, and it is important to diagnose it in its incipient stage of intermittent claudication, progressive weariness of the legs on and after exertion, coldness independent of the external temperature and impaired sensation: these symptoms are associated with absence of pulsation in the arteries, a sluggish circulation as shown by lividity and slow return of colour after pressure, and coldness and loss of sensation to touch. Much can be done to avert gangrene by physical methods and particularly is it essential to avoid trauma such as amateur chiropody, ill-fitting shoes, knocking or getting the foot trodden on in crowded places. The general outlook with gangrene is poor even if sepsis is avoided by chemotherapy, for surgery is seldom feasible in the very old and they are condemned to bed with the prospect of progrssive deterioration.

Genito-Urinary Disease.

Chronic infection of the urinary tract and stone formation, both the result of a sedentary or bed-life, will occur, and in both conditions symptoms may be completely absent. As in diabetes, the diagnosis may depend on routine examination of the urine and while the arteriosclerotic kidney and heart failure will produce albuminuria, the blood urea is not more than doubled. Uræmia is more often seen as a result of obstruction or from factors outside the kidney, for intrinsic renal failure is uncommon in the very old.

Cancer.

The silent and slow progress of cancer of the alimentary tract in old age has been noted, and though this is the commonest site, it is a feature of cancer elsewhere. It may be found on routine examination causing no symptoms, and without the history that is characteristic in younger people. It may only

be revealed as the primary cause of deterioration when it has produced secondary effects such as pneumonia, heart failure or severe anæmia. For this reason the period of survival after cancer is diagnosed may be short though the growth has been present for years. Contrary to popular belief, cancer in the aged is not painful and many who have died quietly and painlessly where it has been thought that death was due to " senile decay " are actually found at autopsy to have died of cancer.

Yet even allowing for the difficulty of diagnosis and the smaller proportion of post-mortem examinations that are done, my own experience is that cancer is not as common as one would expect in old people. Because of the general condition radical surgery is seldom indicated or possible, though it is occasionally useful in eradicating distressing symptoms.

Senility.

However hard one tries to decide what disease process is at work or what system is predominantly failing, there will be a number of cases where the only diagnosis that can be made is the vague one of Senility. There is a slow but progressive deterioration of all the functions though each system appears to be able to cope with the decreasing demands caused by a general loss of vitality. The senses fail, movements cease, volition disappears, and though an interest in food is usually the last remaining spark of life, appetite and the desire or ability to eat go at last. These patients exist like vegetables and need to be tended like flowers though this analogy breaks down when one realises that they are invariably incontinent. They may live long in this hopeless and helpless state. Of them particularly is Seneca's famous dictum true: " *Senectus ipsa morbus est*," for with them old age is itself a disease.

TREATMENT.

Before starting any line of treatment in the old, two questions must be answered :—

Will the treatment prolong life, and if so, will that life be more tolerable ?

Will the treatment relieve the patient of the symptoms which are troubling him, with no danger of producing others perhaps more troublesome ?

These are the two questions that most interest the patient even if he is too ill, too dulled, or too shy to ask them. If they are satisfactorily answered, then the line of treatment is justified. Surgery is far from contraindicated in the old and if it will prevent misery and discomfort, the risk to life should not weigh unduly. Too little surgery rather than too much surgery is done in the aged and much suffering can be saved if this very reasonable risk is more often taken. It is astonishing how well the old withstand an operation, even an emergency one, but it must be remembered that though some are old because their lives have been sheltered, the majority are alive because they are made of good material.

The principle of rest, and particularly of rest in bed, needs some modification in old people. The bodies of the young, if not their minds, tolerate immobility remarkably well, but the old must be kept moving as much and as long as possible, for movement is essential for both body and mind. Incarceration in bed is often tantamount to a death warrant, for the stream of life appears to silt up and the mind becomes broody. For instance, six to eight weeks in bed is sound treatment for a coronary thrombosis in a middle aged

person but if this is rigidly insisted on in an old person, mental deterioration may occur or the patient succumb to hypostatic pneumonia, pyonephrosis, or pressure sores. Whenever possible the old must be got out of bed once a day and they must be encouraged to change their position in bed at reasonable intervals. Crippled and arthritic cases must be encouraged to keep moving as much as possible. I am afraid this ideal has often to be abandoned owing to the absence of the hands that are needed to help old people in and out of bed, or to change their position in bed. Particularly is this so in institutions which are always short of staff and where the bed patient is an easier problem. Heart and lung cases are often better treated in a chair than in bed.

Depressant drugs play a large part in the treatment of the old. Lack of sleep is apt to be an obsession in old people and they exaggerate the lack of it; hypnotics are needed more on occasion than as a routine and a hot drink or alcohol as a "night-cap" are both excellent substitutes for the sleeping draught. For pain and discomfort, opium is the drug of choice and when needed it should be given generously; opium by mouth rather than morphia by injection is better for routine use. The barbiturates and bromide are great standbys but they are not tolerated as well as opium and may produce confusion if given as a routine; the combination of a good dose of a barbiturate with morphine is often lethal.

I think you will find that the relationship between the aged and the rest of the family is remarkably good, particularly in the poorer homes where conditions are more crowded and unsuitable, but occasionally the doctor is called in to make necessary adjustments to keep the peace. The hale members of the family will occasionally tyrannise the old but this is uncommon, for in the home where there is selfishness and lack of sympathy, the unfortunate aged one is bundled off, or takes himself off, to some institution. These are pathetic figures for their only interest in life is their children and of these they are now ashamed. One must be careful, however, not to let one's sympathy for the old unbalance judgment, particularly when one sees them away from the home, for it must be realised that often they can be intolerably trying and what may seem cruelty on the part of the healthy is merely protection of themselves and their children from the unreasonable exactions of those who have had their day. The tyranny of the old over their dependents and children is probably less common than it was, but one still sees the selfish old woman, and less commonly old man, who uses her will to victimise "devoted relatives," usually an unmarried daughter whose life has never been allowed to flower; in such cases it may be justified to incite rebellion. It is not only the large fortune which can be misused, for riches are relative, and in a poor family a few sticks of furniture may be used as rods of tyranny.

I think one is apt to forget in treating the aged that they have a right to be taken into one's confidence. It is so easy to talk to the relatives and forget the patient. Remember that most old people imagine that any illness is liable to be their last one. If this is not so, they must be told so; otherwise they are apt to assume that they must die, and they are then likely to do so. Remember also that in many people there is no wish to live, for there is nothing to live for, life has no savour, and the orange has been sucked dry. "When the evil days come and the years draw nigh, when thou shalt say, I have no pleasure in them"—then is the time when it is no kindness "officiously to keep alive."

The Annual B.D.S.A. Conference at Leeds

I WAS fortunate to be one of the three delegates from Guy's to attend the Annual Conference of the British Dental Students' Association in Leeds; since few students are very well aware of the activities of the B.D.S.A., I thought it might be of interest to give some account of the proceedings.

This was the first year that delegates from foreign countries were present, as well as from all over Great Britain; the countries represented were America, Norway, France, Sweden, Denmark, Holland, Belgium and Eire.

We were very comfortably accommodated in one of the Halls of Residence, situated about a mile from the University. Here students of all Faculties are together, and medical and dental students are not isolated as in London University. This seemed to have a considerable effect on general student life, and the social amenities provided by the University Union were really amazing compared with our own in London University.

The B.D.S.A. is slowly gathering respect and official recognition from the authorities associated with the dental profession. First the ceremony of the Conferment of Honorary Degrees of Doctor of Philosophy on Mr. H. A. Mahony, Principal Dental Officer, Ministry of Health, and on Mr. W. G. Senior, Secretary of the British Dental Association, took place at the Conference. Then the Lord Mayor of Leeds received the Delegates and entertained them at a Civic Reception at the Leeds Civic Hall. Later we were honoured with an address by the Minister of Health, the Rt. Hon. Aneurin Bevan, who had flown up from London. The begining of his speech coincided with a violent thunderstorm, which prevented his speaking for ten minutes. However, he proceeded to give a rather rosy account of the dental services provided by the proposed Health Bill. Apart from the assurance that dental technicians will not be permitted to carry out operative procedures that are normally performed by the dentist, he did not dwell on any of the well-worn controversial matters. In informal discussions with Mr. Bevan later, we gained the impression that he was a little more sympathetic to the Profession than we had anticipated.

As if to dispel any cares that Mr. Bevan may have left, we spent a very enjoyable evening touring the Yorkshire Dales in motor coaches.

At the Leeds Dental School, we were shown specimens of work, colour films, and some very interesting clinical cases by Prof. Talmage Read; these clinical cases covered a wide field of dental surgery, including treated cases of Tic Douloureux and actinomycosis. While we noted that possibly a higher standard of technical skill is demanded at Guy's, we were surprised (and a little pained) to find that the name of Guy's did not command such respect as we had imagined.

Among several interesting lectures, one by Professor Dicks entitled "The Human Being Behind the Denture," was particularly interesting. He outlined the superstition that primitive man held concerning teeth and hair, and how these dormant attitudes of mind might be aroused when the psychological balance of the mind was not very stable.

The Annual General Meeting was held on the Friday of the Conference; it was disclosed that in future the B.D.S.A. will most probably receive financial support from the three Dental Associations, and clerical assistance from the

B.D.A. as well. This will put the B.D.S.A. on the same footing with the Professional associations, as the B.M.S.A. has with the B.M.A.

Apart from the somewhat abstract work of maintaining contact between British dental students, and representing their interests in such matters as free burs, and coupon free white coats, the Association has published a Journal, which it is hoped will be issued three times a year. Dental schools in all parts of the world have been approached, and correspondence has now been started between British dental students and members of many of these schools. The culmination of this International activity has been the attendance at the Conference of so many foreign delegates, who are all returning to their own countries determined to start organisations similar to the B.D.S.A.

The Conference closed with the Annual Dinner and Dance. At the Dinner all the foreign delegates and the Secretary of the B.D.S.A. expressed their appreciation of the generous hospitality extended to the Conference by the Leeds University and Dental School.

The delegates from Guy's returned, feeling that it was a pity that so few had represented this, the largest Dental School in the country, at this Conference at which such a diversity of opinion on dental matters had been encountered, and such a pleasant and instructive time had been enjoyed. It is to be hoped that more students from Guy's will visit the next Annual Conference, which will be held at Bristol next July.

L. G. RICHARDS,
Hon. Sec., S. Region, B.D.S.A.

"The Duke in Darkness"

By PATRICK HAMILTON.

(Presented by the Guy's Theatre Club in the Physiology Theatre, August, 1947.)

THERE are a variety of techniques employed in the writing of a criticism of a play, ranging from the pungent witticisms employed by a well-known film critic, to the more obtuse, classical, approach of the late Mr. James Agate. The former is much the simpler, and has an advantage all its own in these days of paper shortage. For instance,

"The Duke in Darkness"—and so were the audience.

Or, if you want to be downright rude, you can simulate the critic who wrote, "This play was originally written in a lighter vein, but it has now, unfortunately, become varicose."

This perfunctory dismissal, however, is not to be the fate of the Guy's Theatre Club, for in producing "The Duke in Darkness," MR. TONY BREWIN has not only staged his best production to date, but he has reitetated the fact that we have in the hospital to-day some actors of outstanding ability.

The history of the play alone would be enough to damp the ardour of the most enthusiastic amateur company, for besides being almost unknown to the general public, it ran in the West End, in spite of a brilliant cast, for only a few weeks. Its setting, in a 16th century French castle, would tax the ingenuity of the most assiduous stage manager, if he had the best of stages, let alone if he had to make do on improvised iron scaffolding.

These difficulties, however, were triumphantly overcome, and it is greatly to the credit of the "back room boys" that they could produce such solid and realistic scenery. The lighting was especially effective, and the storm was so subtly introduced that some members of the audience involuntarily looked about them to see if it was really raining. The costumes, which were those of the original West End production, might well have been especially made for the cast, MR. RODNEY LONG, in particular, being the height of sartorial perfection.

The first act of the play consists almost entirely of dialogue between Gribaud and the Duke of Latteraine. This would excusably tend to become rather tedious, but we were spared any monotony by the brilliant acting ability of the two main characters. MR. BERNARD MALLET, as the Duke, gave a magnificent performance, which seemed little short of miraculous when we learn that he took on the part—the longest in the play—at only three weeks' notice. His portrayal of a blind man was extremely skilful, and his well modulated dignity did much to enhance the servile insanity of Gribaud. In the earlier scenes he was, of necessity, rather over-shadowed, and it was not until he held the stage in the last act, that we fully appreciated the extent to which he held the play together.

It is no reflection on the rest of the cast, however, to say that the play was dominated throughout by MR. MICHAEL COPLANS, as Gribaud. Even allowing for the fact that the part might well have been especially written for him, his performance was quite outstanding. Any tendency to overact was strongly resisted, and both on and off the stage he exerted such an influence that the play was dominated by his personality. He did not act the part, he lived it, and with his death early in the third act, the play died too. One cannot pay him a higher tribute.

The rest of the cast stood up well to the high standard set by Mr. Coplans and Mr. Mallet. As Voulain, MR. TED MCGUIRE, gave a very steady performance. My chief criticism of him was that he was not volatile enough. This was most noticeable in the scene where the Duke fails to recognise him as his servant. This alarming situation failed to perturb Voulain as much as we might have expected, and left one with a sneaking feeling that he must have read the play before, and so was aware of the happy ending to be.

Mr. Tony Brewin, as the Duke of Lamore, gave the faultless performance we have come to expect from him. This, in spite of an attack of laryngitis which severely handicapped him. His rendering of the mildly intoxicated Duke was particularly convincing.

Of the minor parts, MR. ARNOLD MENDOZA (Brulart) gave the most polished performance. Mr. Rodney Long (Count D'Aublaye), who had to spend long periods on the stage with nothing to do, did nothing with considerable conviction. He was, however, a little difficult to hear at times, as he spoke rather rapidly. The remainder of the cast were good enough when holding the stage, but fell into the common error of thinking they were unnoticed when they were not actually performing.

Mention should be made, in conclusion, of two facts. Firstly the make-up, which was first-class, and, secondly, that not a single cue was missed in any performance. The latter is a remarkable achievement, and is a significant pointer to the endless work that was put into the production of the play.

The future is for the club to decide, but if they can continue to put on such ambitious productions with such triumphant results, they can be certain of full houses whenever they appear, and in whatever places they see fit to perform.

R.A.K–E.

Sport

GOLF SOCIETY

STAFF *v.* STUDEFTS

On Wednesday, July 16th, we played our return match with the " Staff." The match was played at the Royal Blackheath Golf Club and this time the " Staff " got their revenge by beating us by three matches to one with two halved. We were sorry some of the other golfing enthusiasts on the Staff were unable to get away for the match, but we hope to see them when we hold our next " Staff " match in the early part of next year, when we will revive the pre-war custom of an all-day fixture.

MATCH *v.* ST. BARTHOLOMEW'S HOSPITAL.

On Wednesday, 23rd July, we played St. Bartholomew's Hospital in the University of London Golf League at Royal Blackheath Golf Club. It was a very close match and we suffered our first defeat in the League by 4 matches to 3.

Bart's team was somewhat strengthened by the inclusion of three students from America, Smith playing very fine golf to complete the last nine holes in 33 for a total of 71 which was 3 under bogey.

Results of matches were:

STAFF.		STUDENTS.	
Dr. J. Whillis Mr. W. D. Doherty	0	D. F. Cottier M. J. Quelch	1
Mr. N. L. Eckhoff Dr. J. G. Matthewson	1	W. E. Price J. D. Crowlesmith	0
Mr. W. G. Cross Mr. G. M. Johnson	½	D. M. Griffith Maclean	½
Dr. F. A. Knott	½	J. C. Harrington	½
Dr. K. S. Maclean	1	W. Vans Agnew	0
Dr. K. S. Maclean	1	J. M. D. Grant	0
	4		2

GUY'S.		BARTS.	
W. Vans Agnew (1 up)	1	Graham Stewart	0
J. M. D. Grant	0	Smith (4/2)	1
D. F. Cottier (1 up)	1	Jay	0
J. K. Anderson (2 up)	1	Thomas	0
D. M. Griffith	0	McWilliams (5/3)	1
J. D. Crowlesmith	0	Cassels (1 up)	1
M. J. Quelch	0	Hague (6/4)	1
	3		4

J. M. D. GRANT,
(Hon. Sec.).

Hospital Appointments

The following appointments and reappointments have been made by the Governors of the Hospital for the period commencing 1st October, 1947:—

V.D. DEPARTMENT.

Assistant to the Director (Female).
Miss J. H. Morton, M.D.

Medical Officer (Male).
J. G. Goodhart, M.R.C.S., L.R.C.P.

Medical Officers (Female).
Miss J. Halstead, M.B., Ch.B.
Miss C. Stacey, M.B., B.S.

RESIDENT ANÆSTHETIST.
D. M. Carnegie, L.M.S.S.A.

DENTAL OFFICER TO SALOMON'S CENTRE.
E. A. Lloyd, L.D.S.

DENTAL ANÆSTHETIST TO SALOMAN'S CENTRE.
E. H. Rink, B.M., B.Ch., D.A.

ORTHODONTIC ASSISTANTS.
E. K. Breakspear, L.D.S.
H. A. Buck, M.R.C.S., L.R.C.P., L.D.S., D.A.
M. A. Kettle, L.D.S.

Hospital Information, etc.

NOTICES

Applications are invited from registered Dental Practitioners for the post of Demonstrator in Operative Dental Surgery for attendance on three mornings per week from 9 a.m. to 12.30 p.m. Salary at the rate of £75 × £25 to £125 per session per annum. The appointment is due to commence on 1st October, 1947, and is subject to annual re-election. Application forms can be obtained from the Dean, Guy's Hospital Dental School, London Bridge, S.E.1., and should be returned duly completed not later than Wednesday, 10th September, 1947.

GUY'S HOSPITAL MEDICAL SCHOOL.

Applications are invited for the following appointments :—

(*a*) Tutor in charge of the Preliminary Clinical Period Class as from 1st October, 1947, for a period of two years in the first instance. Salary £750 rising annually by £50 to £1,000 per annum plus superannuation and family allowance.

(*b*) Two Demonstrators in the Physiology Department as from 1st October, 1947. Salary £550 per annum plus superannuation and family allowance.

Forms of application, copies obtainable from the Medical School Office, should be lodged with the Dean not later than 22nd August, 1947.

GUY'S HOSPITAL

Applications are invited for the post of Officer in Charge of Medical Reports and Admitting Officer. Applications must be Medically qualified and should have had experience of Hospital administration in an executive capacity. Salary £1,250 per annum. The successful applicant will be required to join the Federated Superannuation System for Universities. Applications, with names of three referees, should be forwarded to the Dean, Guy's Hospital Medical School, S.E.1, not later than 13th September, 1947.

NURSING STAFF.

There are vacancies for Staff Nurses in the Wards, Theatres, Nuffield House and other Departments of the Hospital. Senior post vacancies occur from time to time. Guy's trainees who are interested should apply to The Matron, Guy's Hospital, S.E.1.

PASS LIST

UNIVERSITY OF LONDON.

M.D.

July, 1947.

Branch I.—Medicine.

P. R. C. Evans — D. P. Nicholson
L. NanceKievill — W. G. Tillmann

Branch V.—Hygiene.

W. E. Greenwood

SOCIETY OF APOTHECARIES OF LONDON.

FINAL EXAMINATION.

July, 1947.

Surgery.

J. A. Stewart

Pathology, Bacteriology and Forensic Medicine.

C. H. J. Van Aswegan

Midwifery.

E. L. W. Leiser — J. A. Stewart

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

M.R.C.P.

A. Bloom — D. M. Douglas
W. J. H. Butterfield — J. D. L. Reinhold
R. A. Craig

OXFORD UNIVERSITY.

July, 1947.

Medicine, Surgery and Midwifery.

R. A. Griffiths — B. V. McEvedy
R. Harvard Davis — A. G. Parks
M. S. Kay — J. H. B. Yale
C. C. Kennedy

The degree of Bachelor of Medicine has been conferred on the above candidates.

APPOINTMENTS

Dr. R. H. S. Thompson has been appointed to the Chair of Chemical Pathology tenable at Guy's Hospital Medical School as from 1st October, 1947.

E. W. Baxter, B.Sc. (Lond.) (Lecturer), has been granted Probationary Recognition as a Teacher of Biology at Guy's Hospital Medical School for a period of two years from February, 1947.

PAPERS BY GUY'S MEN

Atkins, Hedley. Post-operative convalescence. *Practitioner*, 1947, **159**, 87.

Chick, A. O., and Another. Injury to the developing teeth of a monkey. *Brit. Dent. J.*, 1947, **83**, 59.

Douthwaite, A. H. Choice of drugs in the treatment of duodenal ulcer. *Brit. Med. J.*, 1947, ii, 43.

Eckhoff, N. L. Nerve injuries affecting the hand. *Clin. J.*, 1947, **76**, 121.

Forgacs, P. Congenital Heart Disease with isolated inversion of the abdominal viscera. *Brit. Heart J.*, 1947, **9**, 27.

Gibb, C. de W. Fibro-angioma of the right ala nasi in a boy of two years. *J. Laryngol and Otol.*, 1947, **61**, 459.

Macintosh, R. R. Technique of laryngeal anæsthesia. *Lancet*, 1947, ii, 54.

Marre, T. R. Penicillin in Skin Diseases. *Post-Grad. Med. J.*, 1947, **23**, 387.

McEvedy, P. G. Rectal pain. *Ibid.*, 4.

Moody, Robert L. Bodily changes during abreaction. *Lancet*, 1946, ii, 934.

Mutch, N. Dried Alumina. *Quart. J. Pharm., and Pharmacol.*, 1946, **19**, 490.

Nissim, J. A. Intravenous administration of iron. *Lancet*, 1947, ii, 49.

Ogilvie, Sir Heneage. A hundred years of gastric surgery. *Ann. Roy. Coll. Surg., Eng.*, 1947, i, 37.

Parry, L. A. The doctor as detective. *Med. Pr.*, 1947, **218**, 88.

Rake, Geoffrey, and others. Morphological and other characteristics of the agent of feline pneumonitis grown in the allantoic cavity of the chick embryo. *J. Exp. Med.*, 1947, **86**, 1.

Randall, K. J., and another. Penicillin in proteus septicæmia. *Ibid.*, 22.

CHANGE OF ADDRESS

D. G. Horan, M.R.C.S., L.R.C.P., 38, Oxford Road, Whitstable, Kent.

J. D. L. Reinhold, B.M., B.Ch., M.R.C.P., 46, Court Way, Colindale, N.W.9.

MARRIAGES

BAXTER—FINLAYSON.—On 21st June, 1947, in Calcutta, Anthony Ed. Baxter, L.D.S., R.C.S., to Anne Miller Boyd Finlayson, of Cathcart, Glasgow.

MASTERS—HEPPER.—On July 5th, 1947, at St. Paul's Church, Herne Hill, Peter L. Masters, M.B., B.S., of Herne Hill, to Maria Josefa (née Hepper), S.R.N., of Chelsea.

Eds. { D.H.F. H.A.R.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

MEDICINE of the future, so it is claimed, will be the science of the prevention of disease. The accent is to be removed from therapeutics and placed on positive health. For a considerable time now it has been realised that good housing and an adequate diet are the basic essentials of this desired state of affairs, while almost hourly the housing situation deteriorates and commons get shorter. It appears that positive health must wait upon the dollar, while the dollar waits upon the inclination of the British people to roll up their sleeves and work.

But there are paths along which progress can be made in preventive medicine without respect to board and lodging. In the middle of war, Mr. Blaikley and Dr. Knott found and developed such a way. We publish in this issue a report on their work. Their investigation was essentially practical in its conception, and what is far more important perhaps, has been and is, immensely practicable in its application. This is self evident from a perusal of the chart accompanying the article. It demonstrates, we think, the Guy's method, utilitarian, based on clinical material, developed in the laboratory and re-applied and tested in the clinic after fruition.

Some of the best work on the Streptococcus, it is interesting to note, was done in maternity wards in consideration of cases of puerperal sepsis. Here now we have a practical classification of Staphylococci, organisms which have come to the fore increasingly, during and since the war, developed in a similar department. We must regard ourselves as fortunate in having had a clinician, a pathologist, and by no means least, a nursing staff, who were able to co-operate so closely and effectively to produce what will surely be accepted as a most important piece of preventive medicine.

DURING the war years the upstairs restaurant in the College has come to be known as " The Spit." Now at last, the real Spit is open again. If reports are true, the service is courteous, the food adequate, and the price as reasonable as one can expect in these times, while accommodation is double what it used to be. We include two photographs in this issue.

The following note was recently received by the Home Sister :

" Please, Sister, could you arrange for the man to spray Nurse Blank's Room, B2, between the hours of 2 o'clock and 4 o'clock on Friday. Nurse will be off duty and will remove her clothes for him. Thank you.—Mrs. Bloggs.

P.S.—Ants are the trouble."

Some Experiences in the Control of Staphylococcal Infections at Guy's

A Clinical Lecture delivered at Guy's Hospital, on May 12th, 1947.

By J. B. BLAIKLEY, Esq., F.R.C.S., F.R.C.O.G.

GENTLEMEN,—I am lecturing to-day on the control of Staphylococcal infections among the new-born in Maternity units, because during the war years we were much afflicted at Guy's with Pemphigus Neonatorum, and I gained some firsthand knowledge.

There is no doubt that Institutional midwifery, while having many advantages over domiciliary midwifery, also has its disadvantages, not the least of which is the risk of cross-infection among the babies and this can all too easily lead to epidemics, with much illness, sometimes death, and always to a varying degree of disorganisation of a maternity unit with, maybe, complete closure over a period.

A proper understanding of the mode of spread is the first and most important step towards the control of any infection liable to become epidemic and under this head must be included staphylococcal infection—in particular pemphigus neonatorum. I was very fortunate in that Dr. F. A. Knott, Clinical Pathologist and Bacteriologist to the Hospital, was most interested in the whole problem and most anxious to carry out a thorough "field" investigation, and I am indebted to him for almost all the work which we did between us and which we finally published in the Journal of Obstetrics and Gynæcology of the British Empire in October, 1944.

I think it is worth while going into the story of the various outbreaks of pemphigus and the details of our investigations as these will make clear and emphasise, both the mode of spread and the means of control. It seems to me that this is still incompletely appreciated, since I hear, not infrequently, of institutions which have been afflicted with staphylococcal infections, including pemphigus over a period of many months and where attempts at elimination of the staphylococcus have even been given up. Admittedly pemphigus neonatorum of staphylococcal origin is not as a rule a dangerous infection to the child unless it is premature or weakly, but none the less where the babies are infected there is always the risk of some dying, and the risk to the mothers of acute mastitis, puerperal infection of the birth canal and infection of Cæsarean wounds.

Before describing our investigations and results I would like to remind you of the general layout of the Maternity department at Guy's. It is situated in an old building, and consists of two big wards, two nurseries, a 3-bed observation ward and two labour rooms, all very compact with free access between the various parts. The wards were originally medical wards and have been only slightly modified. There are 46 beds and the whole department is cramped and difficult from the nursing point of view. It became therefore all the more important to find a way of controlling these staphylococcal infections. I should add that during the war only 24 beds were in use, and during 1941 and the first three months of 1942 one ward was occupied by general surgical cases, including air raid casualties.

New born babies are of course peculiarly susceptible to infection with the staphylococcus, but for some reason, not clear, there seems to have been a great increase in the infection of recent years—I should say since 1941. We have not time consider why this is, but one is tempted to speculate that during the war years ill ventilation consequent on the blackout and lack of sunshine were both factors leading to an increase of infection among the population in general, and therefore as will be shown, babies in particular. These factors to some extent recur every winter.

At Guy's the first outbreak of pemphigus was towards the end of 1941 and in all there were five definite epidemics, starting suddenly and lasting about three weeks, with clear intervals between each.

The investigation covered a period of two years from March, 1942. During the first year we investigated, during the second we applied the results of the investigations so as to obtain control. While investigating the outbreaks of the first year and maintaining bacteriological control in the second, approximately 8,000 bacteriological specimens were examined by Dr. Knott and his laboratory technicians. Culture of a pemphigus lesion was made after carefully cleaning away the surface material, and in most of the earlier cultures the bleb was punctured aseptically with a fine pipette, rather than swabbed. Cultures were also made with swabs from the nose, pharynx, vagina, catheter urines and hands of the mothers; and from the nose, pharynx and hands of all the staff; and the nose, pharynx and skins of the babies. The initial growth in practically all pemphigus lesions gave a pure growth of staphylococcus aureus. It was immediately obvious, as it has been to many investigators before, that the difficulty lay in sorting out virulent staphylococci from those less virulent, or even harmless. The whole success of the investigation and subsequent control in my opinion depends on the simple, but in practice satisfactory, methods used by Dr. Knott. All pathogenic staphylococci produce pigment (with a very few exceptions), coagulase, and hæmolysin to a varying degree, but it is not possible to sort them out satisfactorily on these characteristics. It is found, however, that fermentation of the sugars varies quite definitely with virulence of the organism, in particular fermentation of mannite, and on this characteristic Dr. Knott decided to grade them. The fermentation tubes, initially of *p*H 7·6 to 7·8 with phenol red as indicator and containing

TABLE I.

	Pigment	Coagulase	Hæmolysin	Gelatin	Mannite	Lactose	Saccharose	Maltose	Glucose	
GRADE A	+++	++	+++	+	A_{24}	A_{24}	A_{24}	A_{24}	A_{24}	A
,, B	+++	++	+	+	A_{48}	A_{24}	A_{24}	A_{24}	A_{24}	B
				—						
				—						
,, C	++	+	+	+	A_{72}	A_{48}	A_{48}	A_{48}	A_{24}	C
		—	—							
		—	—							
,, D	+	+	+	—	A_{72} or —	A_{72}	A_{72}	A_{48} or $_{72}$	A_{24} or $_{48}$	D

All Grade A and B strains are considered invasive and exclusion of the patient or carrier follows.

1 per cent. of each carbohydrate, were inoculated with one drop of a saline emulsion of staphylococcus made up to a standard opacity of approximately 2,000 million per cc. They were incubated at 37°C. We have graded the staphylococci as follows, Grade A being the most virulent and Grade D the least :—

Those that ferment mannite in 24 hours under these conditions are called Grade A, in 24–48 hours Grade B, 48–72 hours Grade C, and over 72 hours, or not at all, Grade D. Naturally a few organisms are borderline between the grades. Those between Grades B and C are upgraded to B. This grading is set out in Table I. In Table II are tabulated the results of cultures from the different infections we met with, and also at the bottom the results of cultures from 50 consecutive " normal " mothers—that is mothers swabbed as a routine and not because of clinical infection in the ward—mothers from whose skins we grew staphylococcus aureus. You will notice that among these fifty only one carried Grade A, and 4 Grade B, but 17 carried Grade C

TABLE II.

LESIONS	Staphylococcal Grades A	B	C	D
Breast (abscess)	3	3	0	0
Breast (Inflamed only)	3	9	5	1
Pemphigus	15	14	2	0
Impetigo	1	2	1	0
Septic rash or boils	9	24	7	3
Septic finger	5	3	1	0
Conjunctivitis	2	16	6	1
Wound sepsis	2	4	0	0
Fifty consecutive " Normal " but + skins in mothers	1	4	17	28

and 28 Grade D, which illustrates what we always find, that Grades C and D are relatively very common. They can in practice be ignored as they never cause epidemics (see chart). It is possible by this grading to identify Grade A and Grade B staphylococci quickly, whereas typing by the Cowan technique, which anyway is not altogether satisfactory, takes longer. In the control of infection it is *important* to identify the virulence of the staphylococci *quickly*.

During the first year, that is the period of investigation, numerous swabs were taken from patients, staff, babies, baths, towels, soap, dust, etc. It soon became evident that the human carrier was probably the original source of infection. During this year the usual precautions, taken in any efficient maternity unit, were in force, such as isolation of infected cases, particular attention to cleanliness and, on occasion, closure of the ward ; but in spite of this five outbreaks occurred. I will briefly describe them :—

In January, 1942, we had 9 cases of pemphigus, 3 of septic skins, 4 cases of acute mastitis without abscess, and one with, also 2 cases of conjunctivitis (" sticky eyes ") in babies. Over the same period 7 Nurses and 2 dressers were found to be carrying Grade A staphylococcus aureus in the nose and throat or on the hands. At the same time positive cultures were obtained

from some dusting powder, a bottle of olive oil, 2 towels used for babies, and a roller towel in the ward kitchen; also, as would be expected, several positive cultures were obtained from bedclothes of infected patients. The ward dust was singularly free and only 3 positive cultures were obtained from 30 samples, the only culture of dust that actually showed Grade A staphylococci was obtained from under the cot of an infected baby. As the investigation started in the middle of this outbreak, its origin is not quite clear, but probably it came from a small girl operated on for an acute mastoid infection in the surgically occupied half of the department, and who was subsequently shown to have a heavy infection with a pure growth of Grade A staphylococcus. In the next bed a patient operated on for appendicitis developed wound sepsis, due to the same variety of staphylococcus, and three days after this the first infection appeared in the maternity department. Enquiries showed that contrary to regulations, two nurses looking after these cases had occasionally used the roller towel in the maternity ward kitchen. The department had to be closed. When it opened again 10 days later the majority of its former staff were again on duty. Strict bacteriological testing had not yet been introduced. Twenty random test samples taken in the department were all free from Grade A or B staphylococci. Within five days infection among the patients had broken out again; the surgical cases had been removed from the adjoining ward a month or so before and the infection must have come from within the department. There were 7 cases of pemphigus, 4 of skin sepsis, 5 of conjunctivitis, 3 of acute mastitis and one case of infection of the genital tract. The routine swabbing of everyone was at once undertaken and 5 of the previously infected nurses were found still to be carrying Grade A staphylococci on their hands or in their noses. Also 2 further nurses were infected. The ward was again closed, complete spring cleaning was carried out and the department carried on in the empty private wing of the hospital. On moving to the private wing care was taken to exclude all persons carrying Grade A or B staphylococci and routine cultures from new patients were started. After a month the department moved back to its own wards, having had no further trouble. For 4 or 5 weeks all was well, but in June a nurse commenced work in the department and by an oversight was allowed on duty without preliminary cultures being taken. This was unfortunate, as she was known to Dr. Knott, being a frequent visitor to the Inoculation Clinics since she suffered from severe hay fever and recurring colds. Repeatedly Grade B staphylococci had been grown from her nose. Among her patients a mother developed a breast abscess (Grade B) and although her baby showed no lesions, those of the mothers on either side developed pemphigus from Grade B staphylococci. Infection spread to 6 nurses producing two septic fingers, also there were various infections among the patients. Immediate exclusion and isolation of those infected seemed to bring the outbreak to an end and the department did not have to close, except for 3 days while extra cleaning, re-sterilisation and re-stocking was carried out. Within a fortnight it was clear of Grade A and B staphylococci. Another outbreak occurred in October, probably as the result of some slackening of precautions. A patient was admitted in the late stages of a severe head cold without being swabbed. Subsequently it was found that she had a marked infection of an antrum with staphylococcus aureus Grade A. She was up and about the ward for several days before her confinement and during this time severe pemphigus developed in two babies occupying cots adjoining her bed, and various other infections occurred; 4 nurses became carriers. Exclusions again controlled the outbreak fairly quickly.

Early in January, 1943, three young babies developed pemphigus. On this occasion re-examination of the nurses demonstrated a carrier with a heavy growth of staphylococcus Grade B in the nose. She had recently arrived from a maternity unit in another hospital which on enquiry was found to be suffering from an outbreak of pemphigus. She had not been subjected to preliminary swabbing. Within a fortnight 12 more cases of pemphigus occurred, also 5 of acute mastitis, one giving rise to an abscess, 5 cases of staphylococcal conjunctivitis and a few very minor infections. The department had to be closed down for three weeks on this occasion.

At this juncture preventive routine based on continuous bacteriological control was introduced. It had been realised—

(*a*) that clinical infection was produced almost entirely by staphylococcus aureus Grades A and B;

(*b*) that on every occasion these staphylococci were introduced by human carriers;

(*c*) that since masks were at all times in use and yet infection spread rapidly, it was unlikely to be by droplet infection as seems to be the usual thing with hæmolytic streptococci;

(*d*) that ward equipment frequently handled had been shown to be infected and was thought to pass on the infection much more rapidly than ward dust.

It was thought probable that a nurse carrying the staphylococcus in her nose, as the result of blowing her nose or rubbing the nostrils, infected her hands and then with her hands, either infected a baby directly or, if not handling the babies, she infected ward equipment which some other nurse then handled, and she in turn infected the babies. Having explained things fully to the ward sisters, and with their full co-operation the following routine was instituted :—

1. All nurses before commencing work in the department and at fortnightly (lately weekly) intervals have their nose, throat and hands cultured. If staphylococcus Grade A or B is grown they are debarred from working in the department until clear of infection; and

2. All students are similarly swabbed before doing their take-in fortnight. In both cases additional swabbing is undertaken in the event of a cold or sore throat.

3. All new admissions are similarly swabbed, and for a time they were kept in a small admission ward until the result was known. If this was positive they were kept in a side ward with, possibly, removal from the department.

4. All personnel wear masks while dealing with babies as well as when attending patients, and except where absolutely necessary a baby is not handled and, most important of all, before and after handling a baby the hands are washed thoroughly for 1–2 minutes, preferably under running water turned on by foot or elbow. The hands are dried on small sterile towel squares which are discarded. (For 18 months this has not been possible for most of the time). The squares having been used once, are laundered.

5. To reduce the handling of babies and to avoid crowding the bathrooms, the babies are bathed as infrequently as possible, viz., after birth, when the cord separates, and then at intervals of 5 or 6 days.

6. After each baby is bathed the whole of the bath and its equipment is thoroughly washed down before being used for the next one.

7. Each day's supply of dusting powder, olive oil or similar applications are previously sterilised in the bacteriological department.

8. Only fathers are allowed to see babies and they must wear masks and may not handle them.

9. Babies are not kept in the ward during visiting hours.

10. Mothers and babies infected with staphylococcus aureus Grade A or B are promptly removed to an isolation ward. For a time no mother was admitted to the 24 bedded ward until swabs were returned negative.

During the following year, although there were a good number of positive swabs among nurses about to be posted to the ward, and among patients arriving in labour, we had no epidemic in the ward, which ran smoothly. The average exclusion rate of staff was 2 per month and the average isolation rate of patients was between 3 and 4 per month. 375 deliveries took place as against 225 the year before. The same number of beds were in use and the difference was due to closure of the ward on several occasions as mentioned. We have continued this routine ever since and have had no further epidemic although we have had occasional isolated cases of pemphigus neonatorum and other staphylococcal infections. Incidentally, all carriers of hæmolytic streptococci Group A are also detected and excluded automatically.

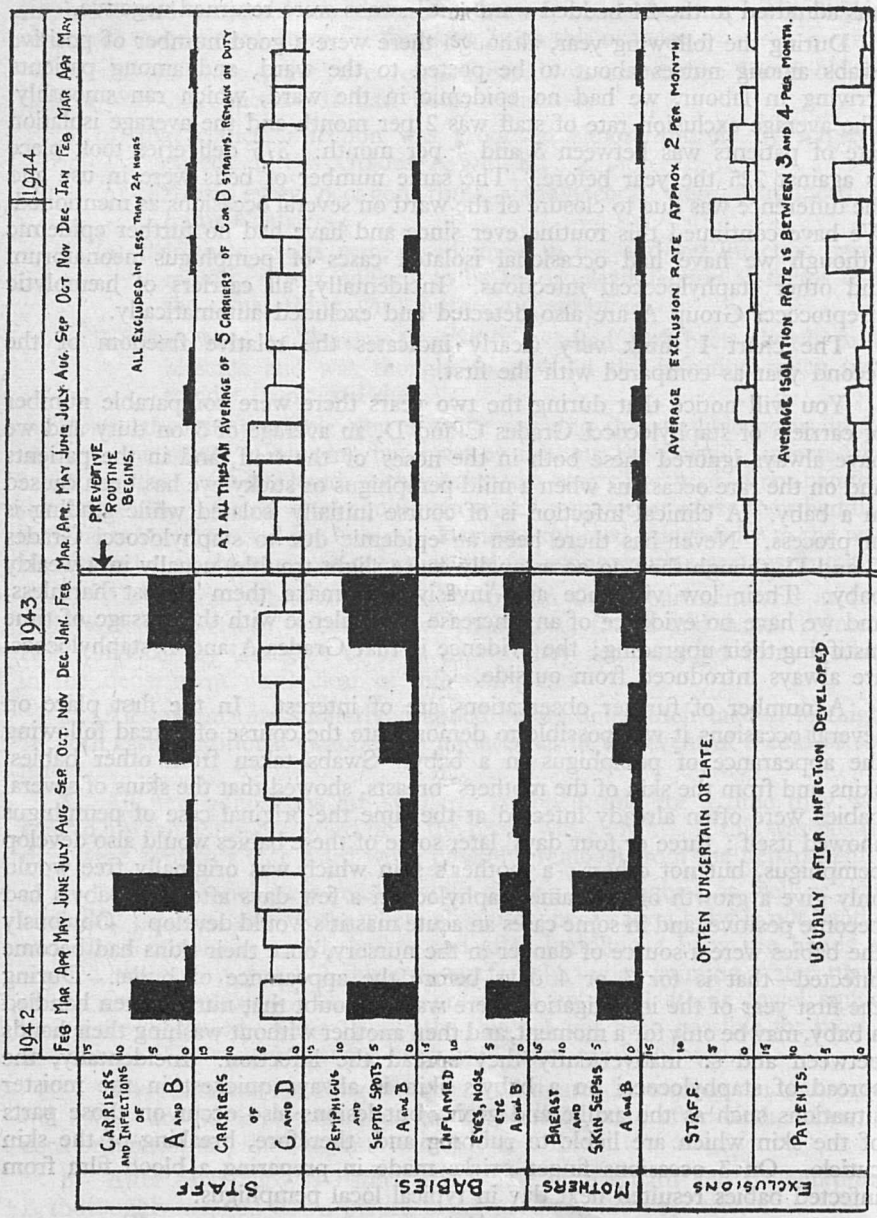
The chart I think very clearly indicates the relative freedom of the second year as compared with the first.

You will notice that during the two years there were comparable number of carriers of staphylococci Grades C and D, an average of 5 on duty and we have always ignored these both in the noses of the staff, and in the patients and on the rare occasions when a mild pemphigus or sticky eye has been caused in a baby. A clinical infection is of course initially isolated while grading is in process. Never has there been an epidemic due to staphylococci Grades C and D, though they do occasionally cause slight trouble, usually in a weakly baby. Their low virulence and invasiveness make them almost harmless, and we have no evidence of any increase of virulence with the passage of time justifying their upgrading; the evidence is that Grades A and B staphylococci are always introduced from outside.

A number of further observations are of interest. In the first place on several occasions it was possible to demonstrate the course of spread following the appearance of pemphigus in a baby. Swabs taken from other babies' skins and from the skin of the mothers' breasts, showed that the skins of several babies were often already infected at the time the original case of pemphigus showed itself; three or four days' later some of these babies would also develop pemphigus, but not others; a mother's skin which was originally free would only give a growth of the same staphylococci a few days after the baby's had become positive, and in some cases an acute mastitis would develop. Obviously the babies were a source of danger in the nursery, once their skins had become infected—that is for 3 or 4 days before the appearance of bullæ. During the first year of the investigation there was no doubt that nurses often handled a baby, may be only for a moment, and then another without washing their hands between and so inadvertently they spread the infection. Incidentally, the spread of staphylococci on a baby's skin is always quickest in the moister situations such as the axillæ and groin, but lesions also occur on those parts of the skin which are liable to rubbing and, therefore, breaking of the skin cuticle. On 3 occasions finger pricks made in preparing a blood film from infected babies resulted next day in typical local pemphigus.

During our observations cultures were made from 52 samples of milk aseptically collected from normal mothers. Staphylococcus aureus was found in 36 of them (70%) but none of these strains belonged to Grade A and only 3 could be classified as Grade B. It seemed to us that a staphylococcus aureus met with in normal milk always belongs to the less invasive strains.

Nasal cultures were made of 48 clinically normal infants 2 or 3 days old who had not been in even remote contact with septic cases. It was found


1942
1943
1944
Feb Mar Apr May June July Aug Sep Oct Nov Dec. Jan. Feb. Mar. Apr. May June July Aug. Sep Oct Nov Dec Jan Feb Mar Apr May
PREVENTIVE ROUTINE BEGINS.
ALL EXCLUDED IN LESS THAN 24 HOURS
AT ALL TIMES AN AVERAGE OF 5 CARRIERS OF C OR D STRAINS. REMAIN ON DUTY
AVERAGE EXCLUSION RATE APPROX 2 PER MONTH
AVERAGE ISOLATION RATE IS BETWEEN 3 AND 4 PER MONTH.
OFTEN UNCERTAIN OR LATE.
USUALLY AFTER INFECTION DEVELOPED
STAFF
CARRIERS AND INFECTIONS OF A AND B
CARRIERS OF C AND D
BABIES.
PEMPHIGUS AND SEPTIC SPOTS A AND B
INFLAMED EYES, NOSE ETC A AND B
MOTHERS
BREAST AND SKIN SEPSIS A AND B
EXCLUSIONS
STAFF.
PATIENTS.

that although 12 (25%) gave some colonies of staphylococcus aureus, all belonged to Grades C or D.

As regards the carriers, it was found that the majority of those nurses who were carriers, were carriers only temporarily, but a very few almost habitually showed virulent staphylococci in their noses and throats. It is now evident that among the former group, the period during which they remain carriers can be reduced to about half by spraying the nose and throat 3-hourly with a Penicillin spray 1,000 units per cubic centimetre. Chronic carriers, such as the nurse who was the source of outbreak 3, should never be allowed to work in a maternity unit.

One other observation I would like to record, viz., the result of testing the air in the wards by means of an air sampler lent to us by Dr. Bourdillon. We found air both before and after bedmaking to be free of Staphylococcus Grades A and B, and came to the conclusion that infection of dust only occurs in a ward where there are patients heavily infected, such as with septic burns. If maternity wards are kept clear of infection, the dust and air will not contain harmful staphylococci and cross infection by dust will not occur. (In a ward full of septic cases it is of course impossible to keep the dust and air free of infection, and cross-infection of wounds is very liable to occur, as Leonard Colebrook has shown, and dust may play a part).

Once staphylococci, Grades A or B, are active among a group of nurses living or working together, a high percentage will become carriers. Dr. Allison working for the Medical Research Council writes to me that in a recent investigation he has found that out of 103 staff, 72 gave positive swabs and in 34, the strain corresponded with the epidemic strain of organism. 28 were also hand carriers ; he found no hand carriers when noses were free of infection. It seems to me that in a general hospital it would be preferable if maternity nurses had their own quarters, including dining room, and did not mix freely with those working in surroundings where they were exposed to sepsis.

I have perhaps not made it very explicit that a septic spot or a sticky eye in a vigorous baby may be due to virulent staphylococci and from this child an epidemic start in the nursery. It is not possible to be too careful in isolating such babies and isolation and observation beds, preferably single rooms, with separate nurseries are required in a maternity unit.

In conclusion, I would emphasise that infection is introduced into a maternity unit by carriers and that the naso-pharynx is the usual site of infection. Dr. Allison has confirmed this during the last two years. He has been able to trace the course of three epidemics in a big maternity unit over two years, using bacteriophages. With bacteriophages it is of course possible to say that two cultures of staphylococci obtained from different sources are of identical strain. He found three strains of staphylococci, the first caused a long-standing outbreak, the second gave rise to a further period of infection, overlapped by an outbreak due to the introduction of a third. Dr. Knott attempted to trace the staphylococci in our outbreaks in a similar way, but had too few bacteriophages to get absolutely conclusive results ; we did, however, to our own satisfaction demonstrate the identity of the staphylococcus in the different outbreaks with that of the carrier whom we considered to be responsible for the outbreak, and on one occasion we found two strains of staphylococci at work simultaneously.

I would also like to emphasise that the continuous bacteriological control of a unit is not very difficult or very time-consuming, if one has the services of a bacteriologist in the unit or near at hand. Continuous bacteriological control far exceeds in value intermittent bacteriological testing. Grading is not a scientifically satisfying method, but is in practice a quick and very practical way of assessing the virulence of staphylococci and of recognising the responsible carrier or carriers from among a group of persons, several of whom may have staphylococcus aureus in their noses or elsewhere. Very few, if any, unnecessary exclusions are made.

The early recognition and exclusion of a carrier is the foundation of success in avoiding an epidemic. After this the next most important precaution is undoubtedly the washing of hands before and after handling a baby.

Finally, I would like to acknowledge the great help we received at all times from the nursing staff, in particular Sister J. Jackson, Ward Sister in charge; also from successive R.O.'s, Mr. H. A. Ripman, Mr. T. L. T. Lewis, Mr. R. Ticehurst and Mr. A. R. Williams. To Mr. A. R. Hines we were indebted for much painstaking and careful laboratory work.

Correspondence

Old Age

SIR,—Dr. Baker's clinical lecture on "Old Age" detonates a subject that has been due to explode for a long time.

In nearly every stratum of society, the people who have had the rawest deal of all for some years, have been the old people.

Ever since county council hospitals began to see themselves as big general hospitals they have tended more and more to fill their beds with young, acute cases and to put the old people on the waiting list. This means that many of them will not live the two or three months they will have to wait, but must die under conditions in which they can scarcely be given decent attention—in small, dark, cold, ill-ventilated rooms where no attempt can be made to examine or treat them properly.

Of course Geriatrics is a speciality, and a very important one; but I do not quite follow Dr. Baker when he says "in which you have a definite appointment."

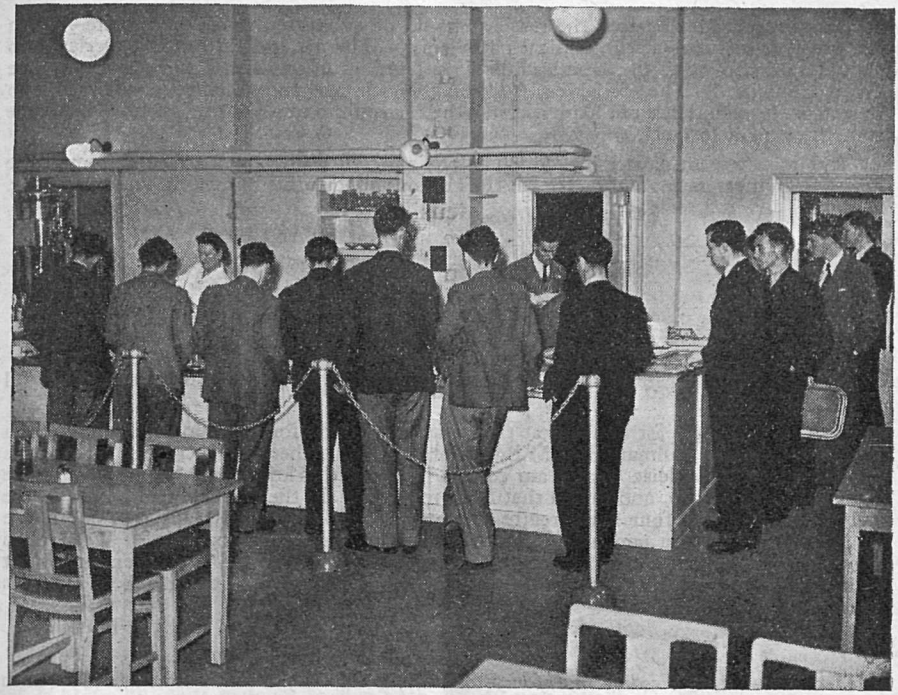
Without any doubt whatever, geriatrics justifies the whole-time attention of "one specialist." The importance of the specialty already exists. It is because we, who have had to look after them have rarely ever been able to examine them under conditions which allow us to do so properly, or, having made a diagnosis, know that directly we try to get a bed for them we shall be told that they will be put on the waiting list, and that there the matter will end. More than once when this cold, stereotyped reply has been given I have got in touch with County Hall (*not* the L.C.C.) and threatened to have a question asked in Parliament—to be rung up about half an hour later by the hospital which had no bed, to say that they have found *one* empty bed.

There is an enormous field for investigation, but it cannot be pursued in dark evil-smelling rooms, with hardly enough room to edge along by the bed.

As far as the history is concerned there is no need to waste valuable time other than that required for the immediate illness.

If a doctor has been properly trained and taught how to use his eyes and his ears, he will probably be able to gather on sight, much that he requires to know—a right hemiplegia with aphasia tells him a mouthful; so does a smell of acetone. I hope Dr. Baker will not think me presumptuous in saying this. I would rather trust my own observation and examination than all the wandering circumlocution of relatives. *But* I should want the patient moved to conditions where a thorough examination and efficient nursing can be carried out. The back history will come, bit by bit.

There is just one point about which I will definitely cross swords with Dr. Baker. It is when he says, "it is true of course that there is less need for an accurate diagnosis as treatment is less often able to effect a cure and is often directed to symptoms alone." That is not the right attitude of mind.



THE NEW SPIT

I am not suggesting that the patient should be submitted to all the torture—for in the old it *is* torture—of the clinical pathologist. The art and skill of the Geriatrician should approximate to the superb clinical skill and intuition of that glorious era of The Great Clinicians. The Hodgkins, Addisons, Pye-Smiths and Goodharts. It may help to restore the confidence of the physician in his own opinion, and to bring back to medicine something of a lost art.

If I may use an expression which is not altogether unknown in the Borough, the geriatrician must *use his loaf* ! He has the glorious opportunity of making a new specialty.

I am, etc.,
STANLEY."

Reviews

A Handbook of Midwifery. By SIR COMYNS BERKELEY. Thirteenth Edition. Cassell *Price* 12*s.* 6*d.*

I HAVE not the least doubt that this is an ideal book for the pupil midwife. Each page bears the hallmark of C.M.B. authenticity somewhere. To criticise its contents would be to criticise what I am certain is the sort of knowledge the pupil midwife is expected to absorb, and far be that from me. But are the five inclined planes of the pelvis (one soft and four hard) really of importance ? Must one really mix one ounce of Dettol to nineteen and a half ounces of boiled water for swabbing ? Wouldn't a pint be near enough ? And when, oh when, will the poor midwife be enjoined, not to summon medical assistance, but to call a doctor ? But I repeat, I'm sure it contains all the right recipes.

H.A.R.

Modern Methods of Feeding in Infancy and Childhood. By DONALD PATERSON. Ninth Edition. Constable. *Price* 8*s.* 6*d.*

THE 9th edition of this little book has now been published. It appears in the modern medical monograph series. Of convenient size for the pocket, clearly printed and excellently arranged, it is a valuable aid to those having to give advice on the feeding of infants and children in health and disease. In its 172 pages it devotes three-quarters of its space to the feeding of the normal child. It places the natural emphasis on breast feeding. Its enunciation of the principles of artificial feeding is well balanced, the details of which, together with the diets for sick children, have the great advantage of being modified in accordance with the availability and restrictions of the present National Dietary. Newer suggestions have been added in connection with the diet in Coeliac Disease. Numerous diet sheets for all ages are given and in themselves make this book an extremely useful one for quick reference.

J.K.M.

Surgery of the Hand. By R. M. HANDFIELD JONES, M.C., M.Ch., F.R.C.S. Second Edition. Messrs. Livingstone. Pp. 163. *Price* 20*s.*

THIS small book on hand surgery is well produced, printed on good paper with clear type and clear diagrams. It describes especially hand infections, the treatment of which has (with the addition of chemotherapy) been standardized since the teaching of Kanaval in the early part of the century. The book provides a synopsis of this teaching which should be of value to students preparing for their exams.

There are about forty pages dealing with " Injuries of the Hand." The complete treatment of the injured hand is a specialised and difficult branch of reconstructive surgery. In many relatively small injuries good results can only be obtained by the use of special plastic methods. Attention in hand surgery in the past has been concentrated on the infected hand, with the effect that results are, on the whole, good. To-day finger injuries, of which the traumatic amputation is the most important, are a bigger problem to accident services. The standard authority on hand trauma is Stanley Bunnell, and much of his teaching on these injuries could have been included in this section with profit. A further point, most surgeons who have to carry out the treatment of deeply burnt hands would not agree that the surgical removal of sloughs delays the production of a suitable bed for the graft.

The book concludes with references to congenital and neoplastic conditions of the hand.

Mr. Handfield Jones has reproduced some of Kanaval's well-known and excellent photos of severe infectives. Hand infections of all sorts are relatively common in every surgeon's experience. The value of any text book on hand surgery would be increased by photos of the author's personal cases and results.

In the opinion of your reviewer this is the best book on the subject available for students to-day.

P.C.

The Birth of a Child. By GRANTLY DICK READ. Heinemann. First Edition. *Price* 5*s*.

DICK READ believes implicitly that normal childbirth should not only be a painless but a pleasurable experience—the greatest, best remembered and happiest in a woman's life. He must be considered as a man with a mission, and a mission of both sociological and obstetric importance. His enthusiasm and conviction are manifest, and this small book leads one to wonder a little what manner of man he is, whether there is not perhaps more in the man and less in the method of his practice of obstetrics, than he realises. None the less, his is a magnificent conception, and should be considered by every accoucheur carefully. It certainly cannot be summarily dismissed. I thoroughly recommend this book.

H.A.R.

Sport

LAWN TENNIS

The Guy's team beat St. Thomas's Hospital in the semi-final of the Hospitals' Challenge Cup on Wednesday, 30th July, at H.O.P., by eight matches to five with two unplayed. In the singles, P. Dwyer won 6—2, 6—2; K. M. Hume won 6—4, 6—1; P. S. Carton-Kelly lost 2—6, 6—4, 2—6; E. Searle won 6—2, 6—2; R. Merrill lost 4—6, 4—6; and D. le Clus won 6—2, 2—6, 6—3.

In the doubles, P. Dwyer and E. Searle beat their first and third pairs 6—1, 6—2 and 6—4, 5—7, 6—1 respectively. K. M. Hume and P. S. Carton-Kelly lost to their first pair 4—6, 1—6, and beat their second and third pairs 7—5, 6—4, and 0—6, 6—1, 6—4 respectively. R. Merrill and D. le Clus lost against their first and second pairs 4—6, 2—6 and 4—6, 5—7.

We meet London Hospital on Wednesday, September 3rd, and look forward to having our captain, Kelsey Fry, playing again.

K. M. HUME,
(*Hon. Sec.*).

CRICKET

REPLAY INTER-HOSPITALS CUP SEMI-FINAL.
GUY'S *v.* ST. MARY'S.

(*Played at Teddington, 23rd July*, 1947)
Guy's : 112 (P. S. Holmes 27).
St. Mary's : 113 for 7 wkts. (R. G. Nicholson 4—11).
Result : Lost by 3 wickets.

GUY'S *v.* ST. THOMAS'S HOSPITAL.

(*Played at the Oval,, Kennington, 9th July*, 1947).
Guy's : 151 for 6 wickets (R. G. Nicholson 49 not out; J. D. Williams 30).
Result : Abandoned, rain.

GUY'S *v.* THREE COUNTIES HOSPITAL.

(*Played at Arlesley, 12th July*, 1947.)
Guy's : 144 (C. H. Talbot 36; J. D. Williams 34).
Three Counties Hospital : 148 for 2 wkts.
Result : Lost by 8 wickets.

GUY'S *v.* BEDDINGTON.

Played at Beddington Park, 13th July, 1947.
Guy's : 71 (J. D. Williams 26).
Beddington : 72 for 0 wickets.
Result : Lost by 10 wickets.

GUY'S *v.* HONOR OAK.

(*Played at H.O.P., 19th July*, 1947)
Honor Oak : 177 for 8 wickets (dec.) (H. M. O'Driscoll 5—29).
Guy's : 112 (H. M. O'Driscoll 42; J. D. Williams 29).
Result : Lost by 65 runs.

GUY'S *v.* KENLEY.

(*Played at H.O.P., 20th July*, 1947.)
Kenley : 178 for 6 wickets.
Guy's : 187 for 4 wkts. (G. P. Billingham 103 not out).
Result : Won by 6 wickets.

GUY'S *v.* OLD WHITGIFTIANS.

(*Played at Croydon, 25th July*, 1947.)

Guy's : 231 for 9 wkts. (J. D. Williams 102 ; H. M. O'Driscoll 50 not out).

Old Whitgiftians : 188 for 7 wickets.

Result : Drawn.

GUY'S *v.* HORLICKS.

(*Played at Slough, 2nd August*, 1947.)

Guy's : 169 (J. D. Williams 50 ; G. H. Talbot 29).

Horlick's : 112 (E. W. Graham 4 for 32 ; R. G. Nicholson 3 for 19).

Result : Won by 57 runs.

Hospital Appointments

NOTICES

1921 INNOMINATE CLUB.

Found.

Silver cigarette case, at the Annual Dinner held May 30th, 1947. Will the owner please communicate with the Hon. Secretary, G. T. Hankey, 89, Harley Street, W.1.

GUY'S HOSPITAL.

Applications are invited for the post of Officer in Charge of Medical Reports and Admitting Officer. Applicants must be Medically qualified and should have had experience of Hospital administration in an executive capacity. Salary £1,250 per annum. The successful applicant will be required to join the Federated Superannuation System for Universities. Applications with names of three referees, should be forwarded to the Dean, Guy's Hospital Medical School, S.E.1, not later than 13th September, 1947.

DEPARTMENT OF SURGERY.

On Tuesday, September 2nd, at 12 mid-day there will be a demonstration in the series of operative procedures.

On Saturday, September 13th, at 10 a.m., Dr. Blalock, Professor of Surgery, Johns Hopkins Hospital, will be conducting a departmental round in Queen Ward.

During September there will be an exhibition illustrating "The History of Guy's Surgery from Astley Cooper to Arbuthnot Lane."

DEPARTMENT OF MEDICINE.

Demonstrations in Dermatology.

Demonstrations in Dermatology are being given by Dr. Barber and Dr. Forman on each Monday at 3.30 p.m. in the Pre-Clinical Classroom.

These demonstrations are for the Dermatological Firm, and graduates and students in their Final Year only.

CHANGE OF ADDRESS

J. R. Forbes, M.D., M.R.C.P., The Emergency Hospital, Wrexham, Denbighshire.

P. C. Grummitt, B.D.S., 194, High Street, Leyton, E.10.

T. N. Reynolds, M.B., B.S., Kidderminster and District General Hospital, Kidderminster, Worcs.

PAPERS BY GUY'S MEN

Robson, J. M., and others. Experimental diphtheroid infectious of the Rabbit's eye and their treatment. *Brit. J. Pharmacol. and Chemothy*, 1946, **1**, 241.

Ryle, J. A. The meaning of normal. *Lancet*, 1947, i, 1.

Smith, R. E. Quarantine, incubation and isolation at school. *Lancet*, 1947, ii, 1.

Swift, P. N., and others. Clinical and Pharmacological aspects of the toxicity of streptomycin. *Ibid.*, 9.

Symonds, Sir Charles. The mechanism of headache. *Clin. J.*, 1947, **76**, 1.

Strickland, W. A. Development absence of permanent canines. *Brit. Dent. J.*, 1947, **83**, 11.

Taylor, Florence E. Learning by seeing : 7. The Skeletal System. Disease affecting bones. *Nursing Times*, 1947, **43**, 439.

MARRIAGES

CARLISLE—IREDELL.—On August 15th, 1947, in London, the Earl of Carlisle, of Naworth Castle, Carlisle, to Esmé Mary Shrubb, younger daughter of Dr. and Mrs. C. C. Iredell, of 34, Christchurch Park, Sutton, Surrey.

HANNAFORD—TOMKIN.—On August 2nd, 1947, in London, William David Hannaford, L.D.S., R.C.S.Eng., of Bridgend, Glam., to Anne Tomkin, of Ripley, Surrey.

BIRTHS

EPPS.—On July 11th, 1947, at Guy's Hospital, to Joan (née Rogers), wife of Philip George Epps, of 19, Lakeside Drive, Bromley Common—a daughter, Judith Mary.

GALLOP.—On July 15th, 1947, at Bournemouth, to Ann (née Harrison Osborne), wife of M. F. Gallop. M.R.C.S., L.R.C.P.—a son (Gerald Maurice).

GARDNER.—On June 17th, 1947, at Red Deer, Alberta, Canada, to Dr. W. J. Gardner and Phyllis (née Pearson)—a son (a brother for Penelope and Peter).

HUGHES.—On August 8th, 1947, to Marjory (née Witcomb), at Bromley and District Hospital —a son.

INGRAM.—On August 22nd, 1947, at 9, St. Leonard's Road, Thames Ditton, to Mary (née Woodhams), wife of Frank L. Ingram, L.D.S., D.M.R.D., M.R.C.S., L.R.C.P.—a sister for David.

LEWIS.—On July 31st, 1947, at Nuffield House, to Bunty (née Moore), wife of T. L. T. Lewis—a son, John Patrick.

MANNING.—On August 12th, 1947, at Wilmar Lodge, to Mary (née Ford), wife of F. R. C Manning, of Epsom—a son.

DEATH

MAYLARD.—On June 27th, 1947, at Kingsmuir, Peebles, Alfred Ernest Maylard, M.B., B.S., F.R.F.P.S.

Eds. { D.H.F. H.A.R.

GUY'S HOSPITAL GAZETTE

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PASSIM

IT is with great pleasure that we welcome to Guy's, Professor Alfred Blalock from the Johns Hopkins Foundation, Baltimore. This eminent surgeon's name is famous throughout the world for his work on the surgical treatment of Congenital Heart Disease and it is indeed a great honour for our hospital to entertain him during his stay in England.

Professor Blalock has, for a short while, left the land of the mighty dollar and entered this austerity island of the frustrated farthing. What will he think of post-war Great Britain in general and, even more to the point, what will he think of Guy's Hospital in particular? All of us on this side of the Atlantic are always assured of at least two things by our American visitors—firstly, of the excellence of our policemen, and secondly, of the horrors of our coffee. What of a British hospital compared with one in the United States?

It is imagined by many of us that all American hospitals are huge, white-stoned edifices somewhat resembling super-cinemas, staffed by sunburnt athletes and nylon-draped glamour girls. Hollywood, in best scientific manner, goes further still and gives the impression that everyone is either "starting the Adrenaline," "stopping the Adrenaline," or "preparing a hypodermic," whilst every operation is performed by a sort of immaculately dressed cricket team and is such a dramatic procedure that even the theatre sister's mascara runs.

Fortunately this description is just so much celluloid fantasy and already we have learnt from Mr. Eckhoff some of his impressions of American surgery and the ways in which their policy differs from ours.

One visitor to our hospital recently described it as "quaint and interesting." The matter was not pursued further, but we flatter ourselves that the quaintness referred to some of our architectural structures and not to our clinical methods, as our visitor, to the best of our knowledge, was not shown any cases that had been either cupped, leeched, or touched for the King's Evil. Nevertheless we must admit that the radiance of Dorcas does contrast *quaintly* with the shadows of Ruth where physical signs lie engulfed in never-ending gloom. Similarly the intermittent outbursts of Works Department Artillery must doubtless make *quaint* music to the unaccustomed ear, and the even *quainter* grumblings of our few functioning lifts can strike terror in the stoutest of hearts, be they of oak or American pine.

During his stay we are sure that Professor Blalock will be able to teach us much of American cardiac surgery and as we understand that the "blue baby" waiting list at Guy's is steadily increasing, it would seem that many of us may have the privilege of witnessing this new kind of operative technique.

An operation performed by Professor Blalock on Tuesday, September 2nd, on a case of Pulmonary Stenosis was, we believe, the first of its kind to be carried out in this country, and thus it is that the skill of a great man may bring honour to a place which, though not his home, is rendered all the more famous for his presence.

THE Harvest Festival Thanksgiving Service will be held in the Guy's Hospital chapel on Sunday, September 28th, at 10.45 a.m. and 9.15 p.m. Flowers, fruit, and vegetables will be gratefully received and should be sent to Matron's Office by Saturday morning, September 27th. These gifts will be distributed afterwards to the patients.

WE regret to announce the death, on May 21st, of Dr. Harry Cooper in his eighty-third year. He was a prominent old Guy's man and well-known to many members of the staff both past and present. On behalf of our readers we extend our sympathy to his widow and family.

The Liver in Amœbic Dysentery

An Undelivered Clinical Lecture by EL HAKIM PASHA.

THOUSANDS of men served in hot countries during the war and suffered from diseases prevalent therein. Nothing is more certain than that many of them will be consulting their doctors for real or suspected residual effects or sequelæ of their old war illnesses for many years to come.

One of the commonest of these troubles was amœbic dysentery.

The primary lesion of this disease is an ulceration of the colon due to infection with entamœba histolytica, but secondary lesions or metastases may occur in liver, lungs and brain.

That the liver should be involved is not surprising, for it is the nearest organ to the site of the primary lesion and is in direct communication with it through the portal circulation.

Involvement of the liver may be visualised as a two-stage process, the first of which is an amœbic hepatitis. If unrecognised and untreated this will progress to the second stage, that of amœbic abscess.

That amœbic abscess of the lung and brain may occur is beyond question, but this requires some qualification.

When I was taught tropical medicine it was impressed upon us that metastases occurred in liver, lung and brain. The impression we received was that metastases in lung and brain were second only in order of frequency to those of the liver.

That view is entirely erroneous.

About sixty cases have been recorded in which brain abscesses have been due to E. histolytica, and these were associated with similar lesions in lung and liver.

As far as I am aware, only five cases of amœbic abscess of the brain, uncomplicated by amœbic lesions elsewhere than the bowel have been recorded. Appreciation of these relative frequencies helps us to maintain the matter in proper perspective.

It sometimes happens that a liver abscess is the first indication that a patient has amœbic dysentery. He may in fact deny that he has ever suffered from any form of dysentery.

An acute amœbic abscess of the liver may develop within a few weeks of a primary attack of amœbic dysentery.

It may be that the most careful questioning shows that the only dysentery the patient will admit occurred eight or ten or even more years ago. Even then he may not be able to tell you whether it was bacillary or amœbic. His description of the illness may be so vague that one may be scarcely able to hazard a guess.

The fact that there is liver involvement is incontrovertible proof that the organism must have been lurking in some concealed ulcer, perhaps for years.

Although the urgency of the liver condition may claim immediate attention, the stools should be searched repeatedly and meticulously for entamœbæ and cysts, bearing in mind the presence of entamœba coli and the possibility of mistaking one for the other.

If I were asked to give the simplest way of distinguishing one from the other, I should say that E. histolytica may contain ingested red blood cells but E. coli never does. There are other ways, of course, which require a certain amount of experience. E. coli may measure from 18 to 40μ against E. histolytica 20 to 30μ. Measurement is not a reliable test, therefore. In fresh E. Coli the nucleus may be distinct, with an *eccentrically* placed karyosome and *coarse* chromatin granules on the nuclear membrane. In E. histolytica the nucleus is not very distinct in unstained specimens. The karyosome is placed *centrally* and the chromatin granules on the nuclear membrane *are very fine.*

The E. coli is sluggish in its movements and its pseudopodia are granular; whereas the movements of E. histolytica are very active and the way it shoots out clear pseudopodia immediately arrests the attention under the microscope.

The presence of ingested red cells is so easily seen even by the inexperienced, that this is a most useful means of identification.

What the two varieties are supposed to look like and what they really do look like is a different matter. I once remember hearing Dobell—surely the great High Priest of intestinal protozoa—say that he would be loth to give a definite opinion on the identity of a single amœba. I have often derived comfort from that remark!

Sooner or later when his general condition permits of it, the patient must be sigmoidoscoped. Parasites may be recovered from ulcers by very gentle swabbing.

If it is true to say of malaria that its response to quinine is often a valuable help in diagnosis, I do not think it would be unreasonable to say that when there is doubt as to whether a patient's condition is one of amœbic hepatitis or whether it has progressed to abscess formation, his reaction to emetine is equally valuable and informative. In the former case the response to emetine may be quite dramatic.

It is a well-known fact that emetine acts much more rapidly and specifically in amœbic hepatitis than in amœbic bowel lesions. If the disease has progressed to abscess formation, there will be no response.

In every case of amœbic dysentery, the possibility of hepatitis occurring at any time must be remembered and a careful watch should be kept on the liver for months afterwards. The occurrence of fever, rigors and pain should excite immediate suspicion. Amœbic abscess may occur as long as twenty years, or even more, after the initial dysentery.

Amœbic ulceration of the bowel may exist for years and be quite unsuspected.

For teaching purposes, it is sometimes an advantage to be brief and dogmatic, leaving experience to dot the "i's," cross the "t's," and effect the refinements.

First of all, the history. The patient should be carefully questioned as to residence abroad and previous attacks of dysentery. This is very important.

He may reply at once that he has had amœbic dysentery and give details which will satisfy you beyond doubt.

He may say that he has "had dysentery" but not know whether it was amœbic or bacillary. Further questions may help. How many times a day were his bowels open? In bacillary dysentery the stools may be "uncountable" and he may be "glued to the commode." In the amœbic form they may not number more than half a dozen. "Was he treated by daily hypodermic injections?" He may or may not remember. Preliminary questioning may be very disappointing. Absence of history of dysentery is no proof that it has never occurred or is not actually present, nor should absence of history deter your investigation of the case.

What are the signs to look for?

In all diseases the text-books contain lists of signs and symptoms, and it is well to remember not to expect to find them *all* in any given case. This is especially true in amœbic liver involvement.

"Rheumatic" pains in the right shoulder are commonly complained of, which are of a referred nature due to irritation of the right phrenic nerve.

Pain and tenderness with a feeling of weight and fullness in the right hypochondrium. Stabbing pains over the liver. Slight rigors, with a temperature rising at night to 102° or 103°—or even as high as 105°—and falling to nearly normal in the morning. The chart may resemble that of a quotidian (double tertian) malaria infection. As many patients admit repeated attacks of malaria, care must be taken not to be misled, a mistake very easy to make. Blood slides may even show malaria parasites to be present, but unless there is also a concomitant paroxysm of malaria these will be gametocytes only, with no evidence of rings or schizogony.

Breathing is short and thoracic, with pain on deep inspiration and a pleuritic rub may be heard over the right base, with diminished T.V.F. and entry of air. Crepitations may be heard—another pitfall which gives rise to an almost classical error, that of a diagnosis of basal tuberculosis.

Emaciation is rapid, and with each rise of temperature there are drenching sweats of the head and upper part of the body. I have seen this mistaken for the "sweating stage" of malaria.

The liver is enlarged and extends below the costal margin. Its area of dullness may be altered by changes of position.

The emaciation may become extreme, and the patient is rapidly exhausted by the profuse sweats and the swinging temperature.

When the abdomen is examined, there may be a fullness in the epigastric angle which ill-matches the general emaciation, as abscess formation becomes well advanced.

There is something almost diagnostic in the picture of a liver abscess at this stage. The muddy complexion, the soaked pillow, with runnels of perspiration trickling down the face and neck. The thoracic breathing and short, painful cough. The extreme emaciation with fullness in the epigastric angle. There may be pain, even in swallowing liquids, as the lower end of the œsophagus is passed. A glance at the temperature chart confirms it.

In some cases there are so few symptoms that the real nature of the case may be overlooked until the abscess bursts into the lung, the stomach or even through the abdominal wall.

I remember being called in to see a patient in hospital who had been admitted three weeks previously as tuberculosis of the right lower lobe. He was a colonial civil servant home on leave from the Gold Coast, and admitted repeated attacks of malaria. He was under the care of a well-known physician who, with his lady H.P., had completely overlooked an amœbic abscess from which we aspirated nearly eighty ounces of " pus " later in the afternoon.

It was said that no malaria parasites had been found in his blood on repeated examination, and that the quotidian type of temperature had been ascribed to malaria so he was put on full doses of quinine, which he was still taking when I saw him. Gametocytes were found later.

The diagnostic significance of his failure to respond to quinine had been entirely overlooked—another not uncommon oversight. I had been called in because frequent examinations of his sputum had shown no tubercle bacilli.

Exactly the same thing happened in the case of an officer in an army hospital, who was dosed with quinine for three weeks. When I saw him it was too late and he died.

In both cases films of the chest taken on admission had shown a raising of the right side of the diaphragm, with definite " domeing," to which no particular significance had been ascribed.

I always remember Sherlock Holmes saying to Dr. Watson, " You *see* my dear Watson, but you do not *observe* ! " *Verb. sap.*

In making a diagnosis it is necessary to consider and exclude non-suppurative hepatitis from other causes, suppurating hydatid of the liver and suppurative cholecystitis, with or without gall-stones. Both hydatid and cholecystitis may complicate amœbic abscess.

Careful history-taking and clinical examination, with a reasonable amount of clinical acumen should put you on to the diagnosis. As in all other branches of medicine the correct interpretation of physical signs and symptoms will come in time as the experience widens.

Once a diagnosis has been made, the answer is *emetine.*

There is unfortunately not time to go fully into the question of treatment beyond the hints already given. I must mention that since the recent war,

the medical journals have been "snowed under" with communications from ex-service medical officers, whose experience of the dysenteries was limited to that campaign. Many of these communications contain intrinsic evidence that the writers were unfamiliar with the extensive background of knowledge which has been built up with the years. They sometimes seem to be uncertain in the handling of anti-dysenteric remedies and perhaps it is scarcely surprising that some of them have even cast doubts upon the efficacy of remedies which have established unshakeable reputations in the estimation of tropical practitioners. The subject is far too big to be dealt with now.

I advise you to read it up in standard text-books; and do not confine yourselves to the writings of one author only. Read several text-books, in fact; for in tropical medicine as in medicine generally, it is a mistake to become the too faithful disciple of one teacher only.

"In the multitude of Counsellors there is Wisdom."

Paris

By F. L. JACKSON, M.B., B.S.; W. P. GURASSA, M.B., B.S.; A. J. BEALE, M.B., B.S.

PARIS has much to offer the visitor—even food, at a price! The medical visitor is especially favoured, as there is for him not only the interest of the city itself but also the buzzing and enthusiastic medical world with its great traditions and its wealth of clinical material. Our recent visit was too short to allow of any real insight into the state of medicine in Paris, but some things we saw and heard may be of general interest.

One of the most famous of the Paris hospitals is the Salpêtrière. Here worked Charcot, and the Charcot Clinic is still to be seen. Axel Munthe, in "The Story of San Michele," has given a vivid impression of conditions at the Salpêtrière when Charcot was at the height of his fame. Before the hospital stands a statue of the French physician Philippe Pinel (1725–1826), perhaps the most famous reformer in the treatment of the insane. Pinel devoted himself to psychiatry after having been profoundly impressed by the plight of a friend suffering with a grave mental illness. He taught the importance of the analytic approach in medicine, following the views of the philosopher Condillac. Various phenomena must be analysed and traced to their origins in organic lesions. In his "Traité médico-philosophique sur l'aliénation mentale," published in 1801, he affirmed the origin of mental diseases in pathological changes in the brain. In 1798 he had obtained permission from the National Assembly to unchain the insane patients in the Bicêtre. Pinel's views had effect in other countries, for Reil advanced them in Germany, and John Conolly in England published, in 1856, his "Treatment of the Insane without Mechanical Restraints."

The Salpêtrière is a large hospital, with extensive grounds, built in the days when ingenious cramping was not a prime necessity of hospital architecture. Most of the buildings are old, but there is a new surgical block. We visited the clinic of Professor Guillain and saw demonstrated a number of cases. One of the cases was an amyotrophic lateral sclerosis with bulbar palsy, here called Charcot's Disease, for Charcot described the condition in 1865. Pro-

fessor Guillain is retiring at the end of June and will be succeeded by Professor A. la Jouanine.

Our next hospital visit was to the Saint Louis, where we hoped to see a demonstration of dermatological cases by Professor Gougerot. We were unlucky, however, for the Professor was away at a Congress in Montpellier. Usually, on Friday mornings, rare dermatoses are shown to students and to foreign visitors.

After this disappointment, we went to the newest of the Paris hospitals, the Beaujon, which is on the north-west outskirts of the city. This hospital was opened in 1935 and has about 1,200 beds. The immediate surroundings of the hospital are not particularly beautiful, but from the roof can be enjoyed an extensive view over Paris. We remembered a similar fine view from Stockholm's Södersjukhuset. The Beaujon hospital consists of a single block and the various departments are arranged on separate floors. There are many small rooms with a single bed in each, and some large wards with about 20 beds. As at Stockholm's Södersjukhuset, there are small rooms where patients may talk privately with their doctors.

We were fortunate here to join a medical ward round conducted by Dr. Ravina. In the course of two hours we saw a wide selection of cases. There were two cases of Typhoid, a disease not uncommon around Paris at present. Next came two cases of subacute bacterial endocarditis, here called Osler's Disease. We might digress to note that Osler referred to a chronic form of malignant endocarditis in his Gulstonian Lectures in 1885. In 1908 he published his paper "Chronic Infective Endocarditis," in the Quarterly Journal of Medicine. As a result of this and other papers, the French sometimes call subacute bacterial endocarditis Osler's Disease. The acute rheumatic form, on the other hand, they refer to as Bouillaud's Disease. Bouillaud (1796–1881) established the relationship of acute rheumatism to heart disease, and it was through his work that a correct conception of endocarditis was developed. He was the first to give an accurate description of the endocardium, and he clearly described the stages of inflammation and organization resulting in cicatrization and deformity of the valves. He recognised too that there is simultaneous inflammation of pericardium, myocardium and endocardium in rheumatism, the state later described as pancarditis.

We next saw a case of agranulocytosis, the treatment being with penicillin and pentnucleotide. Folic acid, we were told, is practically unobtainable in France. A most interesting case was a young woman with tuberculous meningitis, receiving streptomycin. When admitted, she was almost comatose, and it was claimed that she had made excellent progress. Certainly she could move and talk easily, but she still had a positive Kernig's sign and some neck rigidity. The diagnosis was not in doubt, for tubercle bacilli had been isolated from the cerebro-spinal fluid. Streptomycin is very scarce in France, but this patient's husband was having a special supply sent from America. Pencillin seems quite plentiful, and there is a definite tendency to use very large doses.

In addition to these cases, we saw: a tuberculous pleural effusion; a pneumococcal pneumonia; an acute tuberculosis simulating lung abscess in the early stages; a syphilitic alopecia; a bronchial carcinoma; a cirrhosis of the liver with hæmatemesis; a P.U.O. with mottling of the lung fields and no other positive findings; a rheumatoid arthritis; a disseminated

sclerosis; a case with multiple sinuses, almost certainly actinomycosis but awaiting bacteriological confirmation; a bronchitis; a tuberculosis of the hip and a Buerger's Disease. This seemed to us a very good selection for a single round.

After the ward visit, a selection of the cases with heart and lung diseases were screened, the department being provided with its own X-ray apparatus for this. During the round, stethoscopes were not used. A cloth was placed over the part to be auscultated, and immediate auscultation performed by application of the ear. Laennec's discovery was not honoured.

The École de Médicine is an impressive organisation, both interesting and useful to visitors. In the surrounding streets are the main medical bookshops of Paris. The office of the "Association pour le dévelopement des Relations Médicales Entre la France et les Pays Amis" is in the École. Here one may gain information about clinics and lectures, and consult the medical journals of many countries. We learned that, for 500 fr. a year, one may visit any clinic in Paris and examine patients in the teaching hospitals. Of course, life in Paris at present is very expensive, and although M. Ramadier announced that "The state of the franc depends on our nerves," one rather feels when there that the state of one's nerves depends on the franc.

We would warn anyone who might be considering practising medicine in France that, in order to do so, it is necessary to matriculate in France, plough through the seven years course and adopt French nationality—rigorous conditions indeed!

There is much more that could be told about Paris, the Opéra, the Folies-Bergères, Montmartre and the Sacré Coeur, the Louvre, Champs Elysées and the Eiffel Tower, Notre Dame, the bookstalls along the Seine, the innumerable cafés and a host of other aspects of this fantastic city. Details of such things would be out of place in an article confined chiefly to medical matters, but the prospective medical visitor may rejoice that they exist.

We left Paris, our minds crammed with impressions, our pockets empty. We would like to go back again, and we hope that the days when post-graduate study abroad will become a reasonable possibility once more are not too far ahead.

Reviews

Recent Advances in Clinical Pathology. By VARIOUS AUTHORS. Produced under the auspices of the European Association of Clinical Pathologists. General Editor, S. C. DYKE. Pp. 468. 34 Plates. 19 Text Figures. *Price* 25*s*.

THIS book is a further addition to the well-known "Recent Advances" Series. It is divided into four sections, namely: Bacteriology, Biochemistry, Hæmatology and Histology. Each of these has its own Editor and altogether there is an imposing list of 40 contributors, working in different parts of Europe.

There is a wealth of useful information in its pages and it serves to satisfy the need of a single good book which brings together all the aspects of clinical pathology. For not only are there descriptions of the most recent advances, but in many sections descriptions of routine techniques that will be of value to many pathologists and technicians alike. Medical students and nurses too, should benefit from a perusal of its pages, although it has not strictly been written for them.

However, it does appear that with such a large number of contributors the book loses the cohesion which it needs. Too often personal opinions are expressed, which are certainly not generally accepted views. "Too many cooks spoil the broth," and the next edition would greatly benefit from a reduction in the number of authors.

Staphylococcus Aureus is stated as being only "rarely the chief pathogen in sore throat," this is surely inaccurate. Very frequently a pure growth of this organism is seen from the throat of a patient with tonsillitis or pharyngitis.

The chapter on Tuberculosis is disappointing. Nowadays, nearly all laboratories use alcohol for decolorising in the routine Ziehl-Neelsen stain. This eliminates "the saprophytic acid fast bacilli which may be present" in gastric lavage specimens. However, further on the writer states that "smegma bacilli will not resist alcohol decolorisation." It is now recognised that most strains of this organism are, indeed, acid and alcohol fast. Also, vague statements that in Tuberculous meningitis the protein content is increased, and the chlorides reduced are useless unless some figures are quoted.

The chapter on liver function tests leaves the reader more than ever in the dark as to the best way of tackling one of the clinical pathologist's most difficult problems. The writer mentions nearly all the known tests and it is impossible to see the wood for the trees. Surely, it is time that some of the empirical tests, notably the Takata-Ara reaction (which incidentally was originally introduced as a test for pneumonia!) be discarded. In a discussion of the uses of liver function tests as an aid to diagnosis, the writer says that a variety of illnesses other than hepato-biliary disease may be associated with disturbance of liver function. He then goes on to name these under no less than 30 headings which cover practically all disorders known to-day, as well as certain physiological conditions such as menstruation!

With regard to the plates it is felt that nothing can be learnt from a black and white reproduction of H. Pertussis growing on Bordet-gengou medium. The excellent description of normal and abnormal cells in peripheral blood and marrow loses most of its value without a coloured illustration to accompany it.

Apart from these remarks this book can be strongly recommended as the first good English textbook on Clinical Pathology, and its price is reasonable.

K. J. R.

Elementary Physics. By G. STEAD. J. & A. Churchill, Ltd. 1947. Pp. xiv + 547. (Seventh Edition.) *Price* 15*s*.

RECENT advances in nuclear physics have made available a wide range of radioactive substances and have so opened up a new field of biological investigation. This is only one of many contributions which modern physics is making to medical science. Indeed, it is beginning to appear likely that the medical man of the future will need to be more than just "a bit of a physicist" if he is to be fully equipped: at any rate, there is more justification than ever that every medical student should have a good grounding in physical science. The first edition of Professor Stead's book was written over twenty years ago to supply this need. That it is a popular book is evidenced by the appearance of a seventh edition; its success will be vouched for by the successive generations of Guy's men, and many others, who have found it a *vade mecum*. For this new edition, Professor Stead has undertaken a thorough revision of the text. He has introduced a considerable quantity of new material, including an account of artificial radioactivity and nuclear fission, and he has carefully pruned what he describes as "dead wood." He has not forgotten that biological phenomena often have a physical explanation and that physical methods and instruments sometimes have an important medical application. His book can therefore be recommended with confidence to medical students at all stages of their studies. It will also be valuable to senior men qualifying for Post-Graduate Diplomas in Medical Radiology or in Physical Medicine, and to anyone engaged in medicine who wants a straightforward, readable handbook of elemantary physics.

C. B. A.

Correspondence

"The Times"

SIR,—Looking through the advertisements in *The Times* this morning, I see that a lecturer in English—who must have an honours degree—is wanted, at a salary of £500 per annum. About ten pounds a week, in fact.

Also wanted are a House Surgeon to a Gynæcological Department, and a Warden for a Nursing Home who must be a State Registered Nurse—both of these at £200 per annum—say four pounds a week, and both at large hospitals.

While reading the above, a patient came to see me. He was a man aged 22, recently demobilised from the Army and now employed in a neighbouring factory as an unskilled labourer at a wage of eight pounds per week, who only managed to sign his name with difficulty. He told me that he had been offered a vocational training course, but his father, who worked in the same factory, told him to refuse it as long as he could earn eight pounds a week without it.

No comment is necessary.

Yours, etc.,

ACCIPERE QUAM DARE.

5th September, 1947.

Treatment of Tetanus

SIR,—We feel that it is time for reflection upon certain facts concerning the treatment of tetanus, in the light of a rule recently instituted in the Front Surgery stating that all cases seen with a breach of continuity in the skin surface should receive anti-tetanic serum.

The type of wound which calls for anti-toxin treatment is the dirty lacerated wound, contaminated with soil, animal or human fæces, or street dirt; especially if this wound be associated with extensive bruising or devitalisation of surrounding tissues. Under these conditions several factors are operative in the production of clinical tetanus:

(1) The development of anærobic conditions necessary for the growth of the tetanus bacillus.

(2) The production of devitalised tissues which favour the growth of the bacillus.

(3) An inability to carry out a satisfactory wound-toilet owing to the extensive character of the wound, and thus the possibility of a secondary infection with an organism which by virtue of its ability to lower the oxygen tension, may produce anærobic conditions, *e.g.* B. Proteus.

(4) The possible "seeding" of the wound with the causative organism.

Regarding the use of anti-toxin, the serum given at this hospital is made up by a well-known firm in rubber-capped bottles containing ten doses of 3,000 units. The recommended (and practised) prophylactic dose is 3,000 units. This has to be written up and signed by the Out-Patients Officer on the Back-Surgery card. At present, four such bottles are used on the average per day in the Front Surgery. This means that approximately forty patients per day receive 3,000 units of serum. We find it hard to believe that forty cases of injuries of a nature remotely similar to that described above, are seen in Front Surgery in one day. Admittedly, it has been shown that infection with tetanus spores has remained latent for ten years, but the immunity conferred by 3,000 units of anti-toxin lasts, at the most, for only three weeks. In spite of the refinements practised in the production of anti-toxins, the makers admit the possibility of three different reactions: The serum reaction, the anaphylactic reaction, and the thermal reaction.

It seems, therefore, that the present rules governing the administration of anti-toxin should be modified so that the intelligent application of serum therapy to wounds may be re-instituted. The Medical Research Council's memorandum on the anærobic infections states emphatically that even the demonstration of pathogenic anærobes in wound exudates does not constitute clinical infection, for much depends upon local conditions in the tissues. An adequate wound toilet can, and should be carried out on most of the superficial lacerations seen in the Front Surgery. In cases where this is impossible, and where there is obvious contamination and tissue necrosis, the prompt exhibition of anti-serum is clearly justified. Some degree of scientific restraint in the present system of mass administration of serum would result in less delay in seeing patients and less wasteful expenditure on large quantities of anti-serum, whilst the incidence of side reactions, however trivial, which we understand have already occurred in the surgery, would be reduced almost to zero.

We are,

Yours, etc.,

K. F. ANDERSON.
A. S. BLIGH.

Guy's Hospital, S.E.1.

Sport

CRICKET

CRICKET TOUR OF SOUTH DEVON.

For the second year in succession a Guy's cricket side has toured South Devon. Some fourteen assorted cricketers, or so their luggage proclaimed, could be seen spread out at varying intervals along the Great West Road, bowling along in cars ranging from 1947 saloons to an ancient but hardy veteran, which, could it but talk, would no doubt have told many a merry tale of the doings of "W. G." This year accommodation had been obtained on the sea-front at Paignton, not a stone's throw from the Casablanca, that cricketer's home from home on whose exquisitely sprung floor the batsmen of the side could frequently be seen improving their footwork, to the detriment, it is regretted, of those hardy damsels who presumed to take the place of "King Willow" in their arms. Suffice it to say, however, that, eating like kings and sleeping like sardines, we could have asked for no pleasanter surroundings.

The first match was, appropriately enough, against Paignton Town, and they had paid us the compliment of making it their professional's benefit match. A beautiful ground, a perfect day, a holiday atmosphere, a close game—what more could one desire? Paignton won the toss, and, since they elected to bat, we took the field. After a slow beginning, during which our opponents lost two wickets for 38 runs, we had our first glimpse of Routledge, the Paignton professional. With the aid of several partners he took the score along to 132, before he was bowled by Curties—132 for 5. With his departure, however, the Paignton innings was virtually at an end, the remaining five wickets falling for the addition of 12 runs—145 for 10. Our opening pair were separated at 27, and, after Williams' departure at 36, Holmes and Nicholson took the total along to 93, when Holmes was defeated for 41 runs. With 7 wickets in hand and only 49 runs to make we were in a happy position, but time was against us, and, in an effort to make runs quickly, the next six wickets fell for the addition of only 38 runs, our last two batsmen being together, with 15 runs to make, when the stumps were drawn. Routledge took 4 of our wickets for 42 runs, and Oxley 5 for 47.

After a delightful Sunday, torn between the golf course and the sea, we set out on Monday morning looking forward to a good game against the Devon Dumplings on the attractive county ground at Exeter. Williams won the toss, and our opening batsmen started confidently, just failing to make the half-century before Holmes was bowled. The remaining batsmen scored freely on an easy wicket, compiling a total of 182. The Dumplings found Russell in a fierce mood, and Nicholson and Graham full of guile. The only two of their batsmen to reach double figures scored 81 between them out of a total of 123, and the result of a delightful day's cricket was a comfortable victory, Russell taking 4 for 51.

Our next game was against South Devon at Newton Abbott. The ground was a complete contrast to the county ground at Exeter, the outfield being a hardened version of the Valley at Charlton, while the wicket was, to say the least, sporting. Indeed one viewed with a certain sympathy the fate of our opening batsman Holmes, who faces with courage a swift attack on such wickets with glasses gleaming in the sun, defiant for all the world to see. South Devon, however, won the toss, and his ordeal was postponed. Although quite correct to bat, our opponents soon had cause to regret their decision. O'Driscoll was indeed in a militant mood. It was apparent, from the gleam in his eye as he inspected the wicket, that the South Devon batsmen would soon have cause to remember the Irish. In a magnificent spell of eleven overs unchanged he took 7 of their wickets for 30 runs, shattering the sticks on each occasion; indeed the professional could be heard grieving for his stumps in a higher key as each successive batsman turned bewildered to the pavilion. With a total of 71 to surpass, the result was never in doubt, and the game was won by 8 wickets, Holmes scoring 29 and Billingham 34.

Full of confidence after two convincing victories, we set out on the next morning for the lovely village of Chudleigh, with its perfect setting for cricket. Our captain having performed his routine duty of losing the toss, we followed him out on to the field. Our faster bowlers took the first four wickets, three of them falling to Dyer, and from that time on Graham was master of the situation, using his slow spinners with effect to take the last six wickets for 40 runs. Set a total of 105, we started our innings in a disastrous fashion, our first four wickets

falling for 15 runs. Talbot and Dyer, however, coming together for the seventh wicket at a total of 47, passed our opponents score with no further loss, having scored 41 and 31 respectively.

On Thursday, we set out under a cloudless sky for the United Services at Devonport. Once again, accepting the inevitable and with but few muttered imprecations, we followed our toss-losing skipper on to the field. But again our bowlers did valiant work, dismissing our opponents for the modest score of 110, a total which we passed for the loss of one wicket. Talbot made an attractive 64 not out, and Holmes made 22.

The following day we went to Exmouth. Here Williams won the toss! We collected sponges, revived our opening batsmen, and lay back in our deck-chairs to watch them make runs. The shock of batting first, however, was too much for them, and they were both back in the pavilion for 10 runs. Williams, even more graceful with the bat than with the coin, made a beautiful 58, and this, together with a useful 47 by Nicholson, laid the foundation of a reasonable total of 157 for 8. We were forced to hurry to get their wickets before the clock put an end to our efforts. The last one fell to Scott in the last over of the day for a total of 136. Nicholson took 4 wickets for 57, and Woodford took 5 for 45.

The last game of the tour was played at the Royal Naval Barracks at Devonport. Going back to our old routine, we lost the toss, and trooped out into the field. Our opponents scored 158 runs before their last wicket fell, a total which would have been considerably smaller had we maintained the standard of fielding which was set at the beginning of the tour. However, seven matches in eight days, coupled with evenings which, although enjoyable, were not restful, had taken their toll of the side. Woodford took 5 wickets for 23, a very fine performance as support from the field was not forthcoming. Graham, in particular, was unlucky in this respect, having three chances missed behind the wicket from his bowling. Our batting strength, however, was at its peak, and a fine half-century from Billingham, together with a steady 66 not out from Williams, enabled us to pass their score for the loss of three wickets.

We spent that night in the R.A.F. mess at Devonport, as our hotel could not keep us for the last night, and the remainder of the evening was spent in celebrating the end of a very fine tour in a style appropriate to the occasion. It may truthfully be said that this year's tour was a success in every way. The only exception was the very unfortunate injury which Russell sustained to his foot after the first two games, keeping him out of all the others with the exception of the last one. We owe a great debt of gratitude to Mr. Kath, of Paignton C.C., who arranged our fixtures for us, and who accompanied us as umpire to so many of the matches; we hope that he will have as many pleasant memories of the tour as we have.

M. C. G.

Those taking part were

J. D. Williams (Capt.), R. G. Nicholson (Hon. Sec.), G. P. Billingham, R. Curties, H. E. G. Dyer, M. C. Gilbert, E. W. Graham, P. S. Holmes, H. M. C. O'Driscoll, P. S. Russell, G. W. Scott, C. H. Talbot, S. F. A. Westgate, J. F. Woodford.

August 9th (at Paignton)

Paignton 145. Graham 3 for 13, Curties 3 for 21.
Guy's 133 for 9. Holmes 41, Nicholson 39.
Match Drawn.

August 11th (at Exeter)

Guy's 182. Billingham 39, Curties 33.
Devon Dumplings 123. Russell 4 for 14, Nicholson 3 for 12.
Won by 59 runs.

August 12th (at Newton Abbott)

South Devon 71. O'Driscoll 7 for 30.
Guy's 72 for 2. Holmes 29, Billingham 34.
Won by 8 wickets.

August 13th (at Chudleigh)

Chudleigh 112. Graham 6 for 40.
Guy's 113 for 7. Talbot 41, Dyer 31.
Won by 3 wickets.

August 14th (at Mount Wise)

United Services 110. Curties 3 for 27, O'Driscoll 3 for 18.
Guy's 111 for 1. Holmes 22, Talbot 64.
Won by 9 wickets.

August 15th (at Exmouth)

Guy's 157 for 8 declared. Williams 58, Nicholson 47.
Exmouth 136. Woodford 5 for 45, Nicholson 4 for 57.
Won by 21 runs.

August 16th (at Devonport)

R.N. Barracks 158. Woodford 5 for 23.
Guy's 159 for 3. Billingham 50, Williams 66*.
Won by 7 wickets.

Hospital Information, etc.

NOTICES

GUY'S HOSPITAL MEDICAL SCHOOL.

Applications are invited for the appointment of Demonstrator in the Anatomy Department as from the 1st October, 1947. Salary £550 per annum plus superannuation and family allowances. Forms of application obtainable from the Medical School Office to be submitted to the Dean not later than 30th September, 1947.

Applications are invited for the appointment of Medical Registrar as from 1st October, 1947. Salary £500 per annum. Forms of application obtainable from the Medical School Office to be submitted to the Dean not later than 30th September, 1947.

DEPARTMENT OF SURGERY.

On Saturday, September 13th, at 10 a.m., Dr. Blalock, Professor of Surgery at the John Hopkin's Hospital, Baltimore, will conduct a Departmental round in Queen Ward.

On Tuesday, September 16th, at 12 mid-day, there will be a further demonstration in the series of Operative Procedures.

On Friday, September 19th, at 2 p.m., there will be a visit of the International Congress of Surgeons to Guy's.

On Saturday, September 27th, at 10.30 a.m., there will be a Clinico-Pathological meeting in the Anatomical Theatre.

During the latter half of September there will be an exhibition in the museum, illustrative of surgery of Dysphagia.

UNIVERSITY OF LONDON

The following Teachers have been recognised as Teachers of the University and assigned to Guy's Hospital in the subjects indicated.

Dr. Charles Gaffney Baker, M.D. (London), M.R.C.P. (Lecturer and Assistant Physician): Teacher of Medicine.

Mr. John Stanley Bachelor, F.R.C.S. (Lecturer and Surgeon): Teacher of Orthopædics.

Mr. Guy Blackburn, M.A., M.Ch. (Camb.), F.R.C.S. (Lecturer and Assistant Surgeon): Teacher of Surgery.

Mr. John Barnard Blaikley, M.B., B.S. (Lond.), F.R.C.S., F.R.C.O.G. (Director of Department and Assistant Surgeon): Teacher of Obstetrics and Gynæcology.

Mr. Eric John Crisp, B.A., M.B., B.Ch. (Camb.) M.R.C.S., L.R.C.P. (Lecturer and Physician): Teacher of Physical Medicine.

Dr. Philip Rainsford Evans, M.Sc., M.D. (Manch.), F.R.C.P. (Director of Department and Physician): Teacher of Children's Diseases.

Mr. Harvey Harding Kenshole, L.R.C.P., M.R.C.S., L.D.S. (Lecturer and Assistant Dental Surgeon): Teacher of Dental Surgery.

Mr. Francis Rankin Kilpatrick, B.A. (Capetown), M.S. (Lond.), F.R.C.S. (Lecturer and Assistant Surgeon): Teacher of Surgery.

Dr. William Neville Mann, M.D. (Lond.), F.R.C.P. (Lecturer and Assistant Physician): Teacher of Medicine.

Mr. Kenneth Ernest Pringle, L.D.S. (Lecturer and Assistant Dental Surgeon): Teacher of Dental Surgery.

Mr. Philip Vernon Reading, M.S. (Lond.), F.R.C.S. (Lecturer and Surgeon): Teacher of Oto-Rhino-Laryngology.

Mr. Samuel Hall Wass, M.S. (Lond.), F.R.C.S. (Lecturer and Assistant Surgeon): Teacher of Surgery.

Mr. Thomas Henry Hills, M.B., B.S. (Lond.), M.R.C.S., L.R.C.P., D.M.R.E. (Camb.) (Director of Department): Teacher of Radiology for two years from May, 1947.

The following Guy's man has been assigned to the Faculty indicated.

Dr. Francis Edward Camps, M.D. (Lond.) (Lecturer): Teacher of Forensic Medicine at London Hospital Medical College.

Professor G. Stead has been appointed member of the Board of Advanced Medical Studies for the remainder of the year, 1947.

JUNIOR CLINICAL PATHOLOGIST.

Applications are invited for the post of Junior Clinical Pathologist (resident). Duties to commence on October 1st, 1947. The appointment is for a period of six months in the first instance, and the salary will be at the rate of £200 per annum, with board, lodging and personal laundry. The Standing Orders attached to the post can be seen in the Superintendent's Office.

Applications should be lodged with the Superintendent not later than September 23rd, 1947.

CLINICO-PATHOLOGICAL MEETING.

The next Clinico-Pathological meeting will be held in the Pathology Lecture Theatre on Friday, 26th September, 1947, at 2.15 p.m. (Attendance is restricted to Graduates and Final Year Students).

E. R. BOLAND, *Dean.*

STUDENTS' UNION.

Prof. Alfred Blalock, M.D., Surgeon in Chief to Johns Hopkin's University, will address the Students' Union on Thursday, September 25th, at 4.30 p.m., in the Physiology Theatre.

All persons interested are cordially invited.

One of the earliest public showings of the new Ministry of Health film, "The Early Diagnosis of Acute Anterior Poliomyelitis," was held at Guy's on Wednesday, September 3rd. It is many years since the Anatomy Theatre has been so crowded. The showing of the film was followed by a general discussion of the subject, during which Dr. Ralph Kauntze and Dr. Llewellyn Smith answered questions.

The film is to be shown again on Wednesday, September 17th, in the Anatomy Theatre, at 1 and 1.30 p.m.

SOCIETY OF APOTHECARIES OF LONDON.

N. S. Plummer has been sworn-in as examiner in materia medica and Pharmacology.

W. G. Sears has been admitted to the freedom of the Society by redemption.

PASS LIST

UNIVERSITY OF LONDON.

M.D.

July, 1947.

Branch I (Medicine).

P. R. C. Evans — D. P. Nicholson
L. Nanckievill — W. G. Tillmann

Branch II (Pathology).

K. J. Randall.

Branch V (Hygiene).

W. E. Greenwood.

UNIVERSITY OF LONDON.

SPECIAL SECOND EXAMINATION FOR MEDICAL DEGREES.

July, 1947.

D. G. E. Alldridge — J. U. MacWilliam
T. K. H. Baenheim — J. A. M. Martin
D. F. C. Deacon — T. M. Owen
G. Dixon — J. B. Parsons
G. W. Edward — A. R. Phillips
W. R. Edwards — H. F. Pile
N. S. Galbraith — D. L. Rugg-Easey
G. C. A. Holden — P. W. Ruggles

J. V. Jeffs
E. T. J. Jones
T. D. Kellaway
G. A. Lawrence
E. C. Lewis
M. Lewis
W. G. Lewis
K. E. MacLachlan
J. Scorey
I. M. Sharpe
C. Steer
C. B. Vaughan
A. H. Walker
F. H. Walker
A. V. Watts

UNIVERSITY OF LONDON.
SPECIAL FIRST EXAMINATION FOR MEDICAL DEGREES.
July, 1947.

R. K. Allday
F. J. Bateman
E. W. G. Birch
A. J. Bligh
L. H. Brearley
C. P. B. Brook
E. E. Clapham
J. K. H. Culverhouse
G. A. Davis
H. P. Duke
P. G. Dunbar
S. S. R. Earl
L. L. Emery
P. M. Hardiman
E. G. Haydon
P. O. Hirsch
G. J. John
A. V. Large
J. G. Lymbery
D. A. F. McGill
G. A. Marin
W. A. Matheson
E. A. Murray
F. G. M. G. Myer
H. S. Reeve
D. S. Robinson
J. R. Robinson
E. J. Rolls
J. E. Scriven
F. C. Shelley
G. B. Skinner
J. Stott
D. L. J. Thomas
A. Trenhaile
J. C. Walby
C. H. W. Warne
W. C. Whaites
M. L. Wilder
D. C. Wilkins

UNIVERSITY OF LONDON.
THIRD (B.D.S.) EXAMINATION IN DENTAL SURGERY.
July, 1947.
Honours.
*H. A. Buck.

* Distinguished in Pathology and Bacteriology, Pharmacology, Operative Dental Surgery, Dental Surgery and Orthodontics.

Pass.

S. P. Johns
R. A. J. Mayhew
J. D. Morgan
L. A. Rosen

SUPPLEMENTARY PASS LIST.
Passed in Group II.

J. L. Attenborough
P. H. Smith

UNIVERSITY OF LONDON.
SECOND EXAMINATION IN DENTAL SURGERY.
Part I.
July, 1947.
Old Regulations.

P. Glazebrook
P. T. Grimer
M. Kaye
M. M. Keen
P. J. A. Lawrence
L. A. Rees
J. D. R. Shaw

New Regulations.

D. R. Burnapp
J. J. Dickens
W. H. Garland
P. E. Gerrard
P. J. Holloway
B. E. Lawson
H. Levison

The following Students are credited with—
Anatomy and Physiology.

D. M. J. Lyons
C. McEwen
K. F. C. Muncey
H. W. Powell

Part II.
Old Regulations.

R. McK. Carson
H. E. Dyer
B. G. E. Donner
S. P. Gill
N. R. Howells
M. Kaye
M. M. Keen
R. Marx
S. R. W. Powell
T. C. J. Price
L. A. Rees
A. A. Robinson
J. D. R. Shaw
C. B. H. Watson
J. G. Whitelegg

LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICINE.
D.T.M. and H.

M. P. Hutchinson
A. J. Patterson

ROYAL COLLEGE OF SURGEONS.
F.R.C.S.
PRIMARY EXAMINATION.

P. H. Beales
J. P. I. Rose
N. J. Shah
J. H. Smart

ROYAL COLLEGE OF PHYSICIANS.
DIPLOMA IN ANÆSTHETICS.

R. B. Clayton
S. W. Coffin
F. R. Russell

SOCIETY OF APOTHECARIES OF LONDON.
FINAL EXAMINATION.
August, 1947.

Surgery : D. M. H. Bickmore, *A. A. Collis, *M. E. N. Smith.
Midwifery : *A. A. Collis.

*Have completed the Examination.

PAPERS BY GUY'S MEN

Allen, Clifford. Homosexuality: The Psychological Factor. *Med. Pr.*, 1947, **218**, 222.

Clark, D. Stafford. The Medico-Legal Problem of Homosexuality. *Ibid.*, 220.

Eason, Sir Herbert. The General Medical Council and Medical Education. *Brit. Med. J.*, 1947, **ii**, 359.

East, Sir Norwood. Homosexuality. *Med. Pr.*, 1947, **218**, 215.

Franklin, H. R. W. Anæsthesia for plastic and thoracic surgery. *Med. Pr.*, 1947, **108**, 187.

French, J. M., and Another. Dengue in Iraq. *Trans. Roy. Soc. Trop. Med.*, 1947, **40**, 851.

Harding, H. E., and Others. Pneumoconiosis in a boiler scaler. *Brit. J. Indust. Med.*, 1947, **4**, 100.

Harvey, Warren and Shuttleworth, C. W. Sterilization of dental handpieces. *Proc. Roy. Soc. Med.*, 1946–7, **40**, 507.

Johnstone, D. F. Fatal case of Stevens-Johnson syndrome. *Lancet*, 1947, ii, 276.

Kauntze, Ralph. Unusual longevity in aneurysm of the Thoracic Aorta. *Brit. Heart J.*, 1947, **9**, 96.

Lloyd, N. L. The placement in industry of the physically handicapped. *Brit. J. Indust. Med.*, 1947, **4**, 102.

Paulett, J. D. Low back pain. *Lancet*, 1947, ii, 272.

CHANGE OF ADDRESS

E. O. Höhn, M.Sc., M.B., B.S., Dept. of Physiology and Pharmacology, University of Alberta, Edmonton, Alberta, Canada.

Miss R. Schwarz, Government Non-European Hospital, Blantyre, Nyassaland, B.C.A.

St. J. M. A. Tolhurst, M.B., B.S., Devon Cottage, Hampward, Bridgwater, Somerset.

BIRTHS

BRONSDON.—On August 26th, 1947, at Lichfield, to Joan, wife of Noel Bronsdon, L.D.S. (Eng.)—a son (Anthony John).

MALLESON.—On August 27th, at Queen Mary's Maternity Home, Hampstead, to Angela, wife of Montagu Malleson—a third son.

HOLGATE.—On August 18th, 1947, at Guy's Hospital, to Margaret (née Lowe), wife of W. E. M. Holgate—a son (Timothy David).

MARRIAGES

HILLIAM—GRACE.—On September 6th, 1947, Ivor H. Hilliam, L.D.S., R.C.S. (Eng.), of "Rycote," Wimborne Road, Bournemouth, to Phyllis L. Grace, of 39, Suffolk Road, Bournemouth.

MORGAN—EMINSON.—On August 30th, 1947, at St. Lawrence's, Frodingham, Scunthorpe, John K. Morgan, Capt. R.A.M.C., to Verity Eminson, S.R.N.

Eds. {D.H.F. H.A.R.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

IN the near future we shall be welcoming to Guy's a new set of students. Some will come knowing no science except such elements of chemistry and physics as they may have required for matriculation, others will already have their pre-medical examinations behind them, and others still will go straight to the wards, having taken their anatomy and physiology elsewhere. From another aspect, too, they will be varied. There will be those fresh from school, others from Oxford and Cambridge, and even others who having done their service for His Majesty, will be back from the forces. And as their knowledge and experience will have varied, so will their ages be diverse. Probably never before, except after the first world war, has the young entry to the Medical School been so miscellaneous. Who knows who is best equipped? Pages have been written about the education of medical students—year by year the teaching they receive should be better and more appropriate. We think it is. Pages and pages too have been written about post-graduate medical education, and as a result of the recent war, perhaps more has been done to renovate the part-worn practitioner and to encourage the embryo specialist, than ever before.

But a farmer is no farmer who only knows how to sow in Spring and how to harvest in Summer. He must know too how to prepare his soil, and more than that, what soil is suitable to take what seed, something in fact about the rotation of crops.

And so with medicine. Too little time has been spent in considering not so much *who* is suitable to become a doctor, but by what process those with the inclination to heal should be brought to maturity. Now surely is the time for thorough consideration and even for investigation, for now we have, passing through the Medical School concurrently, young boys who at the age of fifteen and sixteen gave up their general education for specialism in science, and at the other end of the scale, grown men who, with no adolescent urge to become doctors, became educated and cultured historians, linguists and classicists before going into the forces, where they met men of all types, they matured in the wood as it were, and having seen the world, or at least a wide sample of its inhabitants, decided to take up medicine. Two soils less similarly prepared one cannot imagine. It seems unlikely that both are right. Is this not the time for controlled observation to see which crop in two adjacent fields yields better fruit or the richer harvest?

As one who surrendered a chance of a good general education and a glimpse of culture, to make a hurried and premature entry into medicine in a misguided attempt to beat time, the writer has a strong opinion on how the last years

at school, when school certificate or matriculation have been satisfactorily passed, should best be spent.

Perhaps on the same swing of the pendulum, if one's opinion was asked, one would advise that the boy on leaving school should do his service in the forces first and come as a man, with a knowledge of the character and varied behaviour of his fellow men, to study the diseases of mankind. Only by a study of the normal may one properly appreciate the abnormal. There is no need for a state of relative emergency and an enforced national service to exist, for such a study to be part of the preparation of a potential doctor. Before the war there were occasionally men who had started life elsewhere, joining us at the dawn of our medical career. We were only at the latter end of adolescence, and ignorant adolescence at that. They always had something that was not in our equipment. It was as if they had been awake two hours or so before us. Some of them found the book work difficult, and in the earlier and more academic stages had a trying time to keep. But in the more practical science and art of medicine—in the wards and in the clinics—while they may have laid their hands on few of the gold medals, they had a way of dealing with patients that one could not but envy.

But be that as it may—it is a personal opinion. The matter is of great importance, not only that the young may have good advice, but that the ill may have good doctors. The time has certainly come for full consideration of the matter, and for the expression of considered opinion.

WITH great regret we have learned of the tragic death of Edward Dunstan, L.D.S. R.C.S., at the age of thirty-five, on August 16th. He took his Dental qualification at Guy's in 1936 and had since served in the R.A.F. during the recent war. Since March this year, he was in private practice in Luton, and his untimely death this summer by drowning, following his rescue of one of his sons in the Blackwater River, Essex, has brought bereavement to his widow and four young children. To them, on behalf of our readers, we extend our sincere and deep sympathy.

OWING to the recently introduced restrictions on banquets, it has been found necessary to cancel the Biennial Dinner, which was to have been held in October, 1947.

The following letter has recently been received by Sister Out-patients, addressed,

"To the Dr. at Back Door, near the Public House at the end of the Building, Guy's Hospital, London."

Enclosure,

"To Sister-in-Charge,

I am unable to attend, no better, no income, only O.A.P., slightly ill."

The patient arrived, aged 91. (O.A.P., for the uninitiated, refers to Old Age Pension.)

Professor Alfred Blalock has been appointed Honorary Associate Consulting Surgeon to Guy's Hospital.

Carcinoma of the Prostate

A Lecture delivered at Guy's Hospital by F. R. KILPATRICK, M.S., F.R.C.S.

GENTLEMEN,—Malignant disease of the prostate accounts for 4 per cent. of deaths from cancer in the male (Caulk, 1937). You will have some idea of its frequency if I remind you that carcinoma of the breast accounts for 20 per cent. of all female cancer deaths, carcinoma of the uterus for 12 per cent. In carcinoma of the prostate the majority of cases occur in late life, the greatest incidence is between the ages of 65 and 70.

Aetiology.

No predisposing cause has been certainly established, but two suggested causes are prostatitis and benign enlargement. There is no clinical evidence that the former leads to a malignant change. Where routine sections are performed on all adenomata of the prostate removed at operation, 5 per cent. are found to be malignant; here there is most likely to be a mistaken clinical diagnosis or the possibility that a carcinoma may develop in a simple hypertrophy of the prostate.

Pathology.

The tumours fall into two groups, according to their cytological appearance: adeno-carcinoma and undifferentiated carcinoma.

The spread of the carcinoma is by:

(*a*) Direct spread. This occurs in the substance of the prostate and proceeds in all directions, to the base of the bladder, to the prostatic urethra and to the vesicles. In addition, it involves the capsule, sheath and surrounding pelvic tissues. Spread to the rectum is delayed by Denonvillier's fascia.

(*b*) Lymphatic spread. This is chiefly to the glands along the vessels which drain the prostate. Thus the internal iliac, external iliac, pre-aortic and sacral glands are involved. In a few cases the inguinal glands are found to be enlarged and more rarely there is generalised glandular involvement.

(*c*) Spread via blood stream. Blood stream spread is common, especially to bone; 25 per cent. of cases have skeletal involvement when the diagnosis is made (Hager, 1937), and at post mortem 28 per cent. of cases have deposits (Muir, 1934). In the bones there is a peculiar distribution of the lesions; this location of deposits is not accounted for by ordinary systemic spread. Batson (1940) has been investigating this problem by injection of radio-opaque substances into the venous side of the circulation. In cadavers he injects the dorsal vein of the penis. This vein of the penis drains into the prostatic venous plexus. In some of these experiments the inferior vena cava is filled out, in others the maximum filling is in the vertebral and paravertebral veins. If the injection is continued the radio-opaque substance spreads via the veins along the vertebral column to the skull.

Batson has also carried out injections on anæsthetised monkeys. The dorsal vein of the penis is injected with thorium dioxide and this is visualised in the caval system. If, however, the intra-abdominal pressure is increased by the application of a binder, the opaque material

is seen in the vertebral and intercostal veins. These experiments would explain the spread of the tumour although nothing quite so dramatic happens as these injections would suggest. These observations also exclude the likelihood of a retrograde lymphatic spread into bone.

Symptoms of Carcinoma of the Prostate.

In a large number of cases urinary symptoms predominate, due to obstruction of the urethra; thus the patients complain of difficult micturition, frequency or inability to urinate. These symptoms are not usually as long-standing as those in patients with simple hypertrophy of the prostate.

In many cases, however, there are no urinary symptoms, but the complaint is of pain in the back, the sacrum, or radiating into both thighs. A bilateral sciatica is extremely suggestive of carcinoma of the prostate, especially if associated with urinary symptoms.

Clinical Findings.

Rectal examination is of the greatest importance in establishing the diagnosis. The prostate feels stony hard, the lateral sulci are no longer present, and the whole of the prostate is firmly fixed. There may be marked enlargement of the prostate; on the other hand, it may be quite small. In a few cases there is extensive spread in the pelvis so that the whole of the pelvis feels "frozen." The rectal mucosa is seldom involved, spread in this direction being delayed by Denonvillier's fascia. It is worth while looking for enlarged glands in the groin, if these are present œdema of the legs is likely to be noticed as well.

Differential Diagnoses.

The following have to be considered:

(1) Prostatic calculi.

(2) Chronic prostatitis.

(3) Simple enlargement of the prostate.

(4) Carcinoma of the base of the bladder.

(5) Carcinoma of the rectum (more rarely).

Investigations.

(1) Cystoscopy seldom helps in establishing the diagnosis, but may occasionally reveal carcinoma of the prostate involving the base of the bladder or a growth of the bladder itself.

(2) Straight X-rays of the pelvis may be very helpful. These may show extensive bone deposits, which are always very dense. On the other hand, a straight X-ray may show that the prostate contains calculi, which account for the hardness found on examination.

(3) Acid phosphatase. Carcinoma of the prostate contains epithelial cells capable of elaborating acid phosphatase. The acid phosphatase is thus raised in a carcinoma of the prostate, particularly when there are deposits in bone. The acid phosphatase readings are as follows: 5–10 units are suggestive of a carcinoma of the prostate, a reading above 10 units is diagnostic of carcinoma of the prostate (Wray, 1945).

(4) The diagnosis may be confirmed by trans-urethral resection.

Treatment.

Radical prostatectomy is applicable only in an extremely small number of cases; where the diagnosis is established early, or where there is a carcinoma developing in simple enlargement of the prostate. Urinary obstruction may have to be overcome surgically by urethral dilation, cystotomy drainage or trans-urethral resection. Radium and deep X-ray therapy have been tried but are not very effective.

Hormone Treatment.

Androgen injections produce a rise in acid phosphatase similar to those found in carcinoma of the prostate. This led Huggins (1942) to advocate orchidectomy, which yielded fairly good results. More recently the same results have been obtained by giving œstrogens to patients with carcinoma of the prostate. These patients are put on stilbœstrol 5–10 mgms. a day initially. The dose can be regulated by the well-being of the patient, and the effect on the bone deposits and the acid phosphatase level.

Prognosis in Carcinoma of the Prostate.

This is difficult to assess, as even with no treatment it is seldom that two cases behave alike. Even in the days before orchidectomy or hormone treatment were carried out, some of these patients survived 3–5 years. With stilbœstrol patients survive longer and are definitely more comfortable. In addition, with stilbœstrol, the deposits in the bone may disappear and the patient who has required supra-pubic drainage may commence voiding urine naturally again. In adeno-carcinoma the response is more satisfactory; in the undifferentiated carcinoma there is usually much less improvement.

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Joseph Towne, 1808—1879

By GEORGE A. R. WINSTON, Wills Librarian, Guy's Hospital.

THERE is an air of romance surrounding the life of Joseph Towne, modellist to Guy's Hospital for fifty-three years, especially in his meeting with Sir Astley Cooper and his introduction to Benjamin Harrison, Junior, the highly-respected Treasurer of Guy's Hospital, when as a youth of seventeen years of age he came to Guy's as an unknown modellist in 1826, and continued to work for the hospital until near his death on 25th June 1879.

He was the third son of Thomas Towne, a dissenting minister of the village of Royston, Hertfordshire, where Joseph Towne was born on 25th November, 1808. His early education was very slender and his life was passed in a quiet country home until he came to Guy's.

As a child his great amusement was modelling in clay and one of his earliest efforts was a miniature monkey. No doubt he had inherited some

of his artistic talent from his father who was a painter of no mean ability. His father also had observed his son's remarkable interest in the art of modelling and decided to make young Towne a pupil of Behnes, the distinguished sculptor.

It so happened that Towne's first work of importance was the model of a human skeleton which occupies a place of honour in the Gordon Museum at Guy's. When it is realised that this model was made by Towne when he was a mere lad of seventeen, that it was moulded secretly, built up from drawings taken from books and such specimens of human bones as could be obtained in his remote village, the accuracy and beauty of the model and the difficulties under which it was formed can be greatly admired. There is a letter in the Gordon Museum, dated February 20th, 1826, from Sir Astley Cooper testifying to its high merit, three months after Towne had celebrated the anniversary of his seventeenth birthday. The model was exhibited at the Society of Arts in the year 1826. Thomas Bryant stated that Towne won the gold medal but Wilks and Bettany gave an account of the award which showed that Towne received the silver medal, that is the second award. In the report to the Royal Society of Arts for 29th May, 1826, it is clear that the Society had for some years been offering prizes for works of this kind, and that the first candidate to be rewarded for anatomical wax modelling was Mr. J. Rutherford Alcock who received the gold medal, and the second prize was given to Towne. The report reads : " It was considered desirable to introduce into this country the art of modelling in coloured wax the parts of the human body in their natural and morbid or dissected state, the many advantages of which will be manifest to all conversant with such studies. Mr. Alcock has sent in a model in coloured wax which well entitles him to the medal, and the silver medal is awarded to Mr. Towne for a very beautiful small model of a skeleton." In the following year, Towne executed some models of the brain in wax and these gained for him the gold medal of the Society.

The work of Towne may be regarded as the first real and serious attempt to introduce anatomical wax-modelling into this country. Attempts had been made by others but all important models had come from abroad, and it is not without interest to note that Towne gained a prize at the first International Exhibition in London in 1851.

The first skeleton that Towne submitted was commenced without knowledge of his family, as he worked in secret and with the dim light of the candle at night. When the model was nearing completion, Towne had the misfortune to upset a piece of heavy furniture that in its fall broke some glass and caused a terrible crash. This awakened his father who then discovered the nature and object of young Towne's nocturnal work, which led to an introduction to Professor Clarke so that Towne junior could compare his model with a similar one exhibited at the Fitzwilliam Museum at Cambridge. This comparison further encouraged Towne but, anxious to obtain an opinion from some high authority he persuaded his father to let him visit London. There he arrived by coach in 1826, a complete stranger, he managed to obtain a room in one of the old inns in Bishopsgate Street.

While wandering in London he sought an interview with a practitioner in Hackney by knocking at a door with a red lamp over it. In this gentleman he found a friend who lent him bones by which the accuracy of his model was tested and who suggested that he should call on Sir Astley Cooper.

Acting on this advice, and without introduction, Towne called on the famous Surgeon, told him of his work and requested an examination of the model. There was an immediate response and when Towne left he had received an invitation to breakfast the following morning with a promise of help.

The next morning Towne took his model to Sir Astley with excited emotion, and as a result of the encouragement and sympathetic kindness shown to him, took heart in the fact that the great surgeon had handed him a testimonial as to the accuracy of his model and a letter of introduction to Benjamin Harrison, by which means Towne became connected with the hospital. Whilst Sir Astley was examining the skeleton and evidently thinking of the practical outcome of such a work he asked Towne: "What do you mean to do—to make skeletons till you are a skeleton yourself?" a story which Towne often told, but it must have been with much satisfaction when it is remembered that Sir Astley lived long enough to witness the great success of the young modellist.

On taking up his appointment at Guy's all that Towne asked for was a room for himself upon which he could turn the key when he liked, and the promise of every kind of help which might be required in undertaking the unknown work he was to originate. He received considerable help from all the physicians and surgeons, but principally from John Hilton, then demonstrator of anatomy, who provided Towne with dissections of inestimable value.

The specimens in the Gordon Museum testify to the magnitude of his industry, not only in the importance of the models in respect of their scientific value, but the life-like representations of what they intended to show, whether anatomical, pathological or dermatological.

These models were the outcome of an entirely self-taught art. The brain models brought forth great praise from Sir Astley Cooper who expressed his high opinion of their merit, and from R. Grainger, an anatomist at St. Thomas's Hospital.

Towne's work was not confined entirely to Guy's. He executed many models for places abroad, and some fine specimens found their way to Calcutta, Madras, Bombay, New York, Alabama, New South Wales and Russia. What was considered one of his finest works was made originally for India, but secured for the Guy's Museum when it was left on Towne's hands following the Indian mutiny. It represented the fifth nerve with all its branches, distribution and connections, and was made of material which would indurate rather than decay by time.

During the years he worked at Guy's Towne executed 200 anatomical models, which were mostly from the dissections of John Hilton; 240 pathological, and 560 diseases of the skin, the majority of which were selected from hospital cases by Thomas Addison. The last models Towne made were a series selected by Thomas Bryant to represent the different degrees of harelip, which incidentally was a series that Aston Key was most anxious to have made.

By nature Towne was destined to be a modeller as he clearly demonstrated by his skill at the early age of seventeen, but he also excelled as a sculptor at which art he was at least as good and no doubt he would have become equally famous had time and opportunity permitted. The busts of Thomas Addison and Sir Astley Cooper were masterpieces. The bust of Sir Astley Cooper, which now rests in the Wills Library, was raised to the memory of

the famous surgeon by his pupils and opened to public inspection by Richard Bright on the 10th May, 1842, after giving away the prizes. A high compliment was paid to Towne by G. H. Bailey, a Royal Academician, who proclaimed the bust the finest likeness extant and even asked permission to correct the head of his own statue intended for St. Paul's Cathedral from a cast of it.

Towne did not confine himself entirely to anatomical and pathological models, and as a sculptor he made an equestrian statue of the then Duke of Kent in 1837, and on the 21st October of that year he was commanded to attend at Buckingham Palace where he had an interview with the Queen. Her Majesty was graciously pleased to express her approval of the work, and the statue was deposited in the Queen's private apartment. A little later he made a statuette of the Duke of Wellington which was presented to the hospital by his daughter, Miss E. M. Towne in 1921 and is still in the Wills Library. There was in possession of the family an autograph letter from the Duke testifying to its goodness. Many other busts and monuments were the works of Towne including an excellent monument of Bishop Otter, which was erected in 1844 in Chichester Cathedral.

Towne was obliged to give up the work of the sculptor as it interfered with his modelling and like many famous men he discovered that to do one thing really well, that is the business of his livelihood, he must often sacrifice the other.

All Towne's work was done in secret. How he made the first skeleton without good bones to model from remains a mystery, as indeed are all the other specimens he modelled for Guy's. He would shut himself up all day in his studio and no one dared enter with the possible exception of John Hilton who is reported to have spent several hours daily with Towne when making the dissections from which the beautiful models were made, and there was apparently a strong friendship and mutual esteem existing between these two very different men. More than anybody else perhaps John Hilton was the person who could have disclosed the secret of Towne's work.

It was stated by Thomas Bryant that on the death of Towne in 1879 his family presented to the hospital the whole of the moulds from which the models were made, and that Towne himself had expressed a wish that such moulds should never be allowed to leave the hospital, but careful enquiries have failed to trace their whereabouts. These are, however, strong indications that the models might have been sculpted.

Whilst discussing with Towne the talent which a great artist had displayed in portraying in bronze the form and figure of an animal, Thomas Bryant was astonished by Towne's criticism that " the animals were good in form and in position, but there was no life in them." At first Bryant was not impressed by this remark but when a few years later he took up an animal of Towne's moulding he was struck by the remarkable form of life Towne had introduced into the model which caused a small child to remark, " Why the giraffe is getting up," and further demonstrated how capable Towne was in imparting the idea of living and moving force into wax or clay. The model was taken from the first giraffe that came to this country and exhibited at the old Surrey Zoological Society's Gardens in 1832. The gardens became the site of St. Thomas's Hospital when it left the Borough and are now built over.

There is another side of the life of Towne which marked him as a man of original and independent thought. In 1839, whilst recuperating in the

country following a bout of bad health, he turned his attention to the subject of incubation of the egg, and on the suggestion of Mr. Harrison he prepared a series of models illustrating the changes which occurred in the egg during incubation. The models made during the eight months he spent on the work were beautiful and his observations were published in the Guy's Hospital Reports in 1839 in 15 figures on 7 plates which included coloured drawings and contained, what were considered, many new points. This work of Towne's has been referred to by several authorities on the subject.

In 1858 Towne delivered at Guy's Hospital a short course of lectures "On the Brain and the Organs of the Senses and of the Intellect," in which he stated that "the eye is a perfect camera obscura and nothing more." This idea he developed subsequently in a series of articles in the Guy's Hospital Reports, commencing in 1862 with an article "On the Stereoscopic Theory of Vision with observations on the Experiments of Professor Wheatstone," followed by articles on "The Stereoscope," "Stereoscopic test for the Eye," concluding with "Physiology of Binocular Vision" in 1866. These papers display a vast amount of ingenuity, originality and talent, full of novel experiments.

Thomas Bryant reports that Towne was a good talker and fond of metaphysical discussions, but at the same time he was reserved and self-contained.

Thomas Hodgkin in one of his lectures said of Towne that "he was an artist who has the signal merit of having both created his art for himself, and arrived at such a proficiency in it that his works, already numerous, rival if not surpass those of the best or most distinguished masters of Florence and Bologna."

Towne left a high reputation that was honourable, true and just. Gifted with such high faculties he created for himself opportunities for progress which enabled him to follow a principle to do nothing less than the best, and the beautiful collection of wax models alone is a sure testimony to the success of his labours.

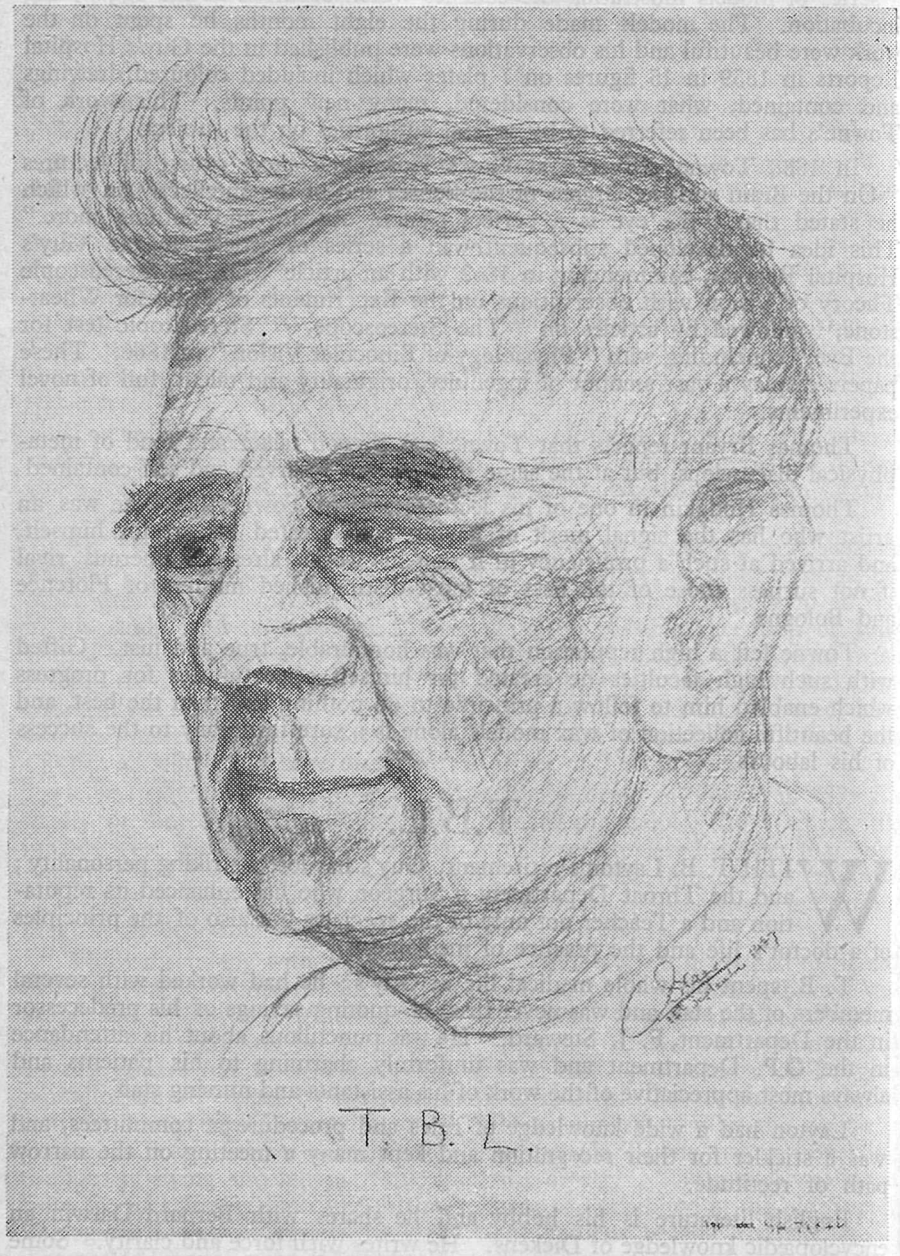
T.B.L.

WITH T. B. Layton's retirement, Guy's has lost a striking personality; and the Throat Department a Surgeon who has enhanced its reputation and a Teacher not only of the specialty but also of the principles of a doctor's life and the practice of medicine.

T. B. spent his whole medical life at Guy's; he had worked with several members of the staff and was never tired of quoting sayings of his predecessor in the Department, F. J. Steward. He was punctilious about his attendance in the O.P. Department and was uniformly charming to his patients and always most appreciative of the work of his assistants and nursing staff.

Layton had a wide knowledge of rules and procedure at committees, and was a stickler for their recognition and kept many a meeting on the narrow path of rectitude.

English literature is his hobby and he shares with Bernard Darwin an encyclopædic knowledge of Dickens. He writes with force and clarity. Some of his older friends will recall with joy Layton's first car. In the days when it was de rigeur for the staff to wear silk hats, T.B. acquired the smallest possible car—this he averred enabled him to thread his way through traffic. Unfortu-


T. B. L.

nately he had to remove his hat before insinuating himself in the car. On arrival at hospital he would emerge from the car with some difficulty—produce his hat from the back seat and walk into the colonnade.

We wish T.B. all good fortune in his retirement. W.M.M.

We feel that a number of old Guy's doctors and nurses, contemporary of Mr. Layton at the Hospital, would be interested to hear of the manner of his farewell.

In 1904, Mr. Symonds had surgical beds in Lydia Ward. Sister Helen Newton, Head-Nurse Neil and Junior-pro Sampson were looking after them while H. J. Knight as dresser was lording it over T. B. Layton as ward-clerk.

In the years between, Sister Newton married and became Mrs. Hugo, Nurse Neil became Mrs. Knight, and Nurse Sampson became Mrs. Layton. Dr. and Mrs. Knight's two sons served Mr. Layton as dressers. Lydia Ward became known as Queen.

On Monday, 9th June this year, Mr. Layton held his farewell round in that very ward, appropriately accompanied by his wife, Mrs. Hugo, and Dr. and Mrs. Knight.

We trust that not only did they enjoy the revival of happy memories, but that T.B.L. and his "Missis" (for whom it must have been a proud occasion), were aware of the warmth of everyone's good wishes.

Correspondence

"Spit"

SIR,—Your use of the word "Spit" to represent the College dining-room, and of the "real Spit" to mean the smoking-room, is an interesting example of the way in which the English language changes; in this instance from the greater to the less for when I came up it meant the Hospital as a whole. I remember it particularly in the 3rd XV, one member of which would ask another whether he was "going back to the Spit" with a view to getting him to take his footer bag and leave it there to avoid his lumping it about in the West-End or other area of Saturday evening enjoyment. I do not remember it in the dignified 1st XV nor do I remember it being used in the wards. It was we small fry of the dissecting-room and labs. that bandied it about. Later I believe it was narrowed from the whole institution to the College and I should put this as during the period of the first war. There are others of the 1900–1901 3rd XV still in existence. Perhaps they would write and tell if their memory talleys with mine.

Yours, etc.,

T. B. LAYTON.

R.A.M.C. War Memorial Fund

SIR,—May I crave a small space in your valuable columns to bring before your readers the claims of the Royal Army Medical Corps War Memorial Fund?

This has been instituted to give help to all ranks of the Corps who have fallen upon evil times through wounds, sickness and other misfortune owing to their service in the recent war and to take care of the families of those who made the supreme sacrifice.

There must be many hundreds of Guy's Hospital men, past and present, who have had war-time contacts with the army, both in military and E.M.S. units, and I feel that perhaps some would like to pay a tribute, however small, to their comrades both of the mess and the barrack room.

I should be delighted to send an explanatory booklet to any who may be interested or to receive contributions sent to the address below or to the Hon. Treasurer, c/o Messrs. Glyn, Mills & Co., Kirkland House, Whitehall, S.W.1.

38 Hyde Park Gate,
London, S.W.7.
(Tel.: Kensington 8131, Ext. 353.)

Yours, etc.,
R. E. BARNSLEY,
Major-Gen. (*Hon. Sec.*).

Hospital Information, etc.

NOTICES

DEPARTMENT OF OBSTETRICS AND GYNÆCOLOGY.

Professor J. M. Munro Kerr, M.D., LL.D., F.R.C.O.G., late Regius Professor of Obstetrics in Glasgow, will give a Clinical Lecture entitled, "Vagaries in the Embedding Site of the Zygote and their Clinical Features," at 1 p.m. on Friday, October 3rd, 1947, in the Anatomical Theatre.

DEPARTMENT OF SURGERY.

On Saturday, September 27th, there will be a clinico-pathological meeting at 10 a.m. in the Anatomy Theatre.

On Tuesday, September 30th, there will be a further demonstration in the series "Operative Procedure" in Theatre 3 at 12 mid-day.

On Friday, October 3rd, there will be a meeting of Surgeons in the Surgeons Room at 4 p.m.

On Saturday, October 11th, a Departmental Round will be conducted in Queen Ward by Mr. Philip Mitchiner, of St. Thomas's Hospital.

DEPARTMENT OF MEDICINE.

Demonstrations by Sir Charles Symonds will take place on Tuesdays at 12 noon in the Pre-Clinical Classroom, commencing on October 7th, 1947.

Demonstrations in Endocrinology by Dr. P. M. F. Bishop will take place at 4.15 p.m. in Out-Patients (2nd floor) on Tuesday, 7th October, 4th November, 25th November, and 9th December.

The next Combined Round will be held in the Pre-Clinical Classroom on Friday, 3rd October, at 2.15 p.m.

(*Only qualified men and those in their final year of study should attend.*)

DENTAL SOCIETY.

The inaugural meeting of the Society for the present year will be held in the Anatomy Theatre on Thursday, October 9th next, at 5 p.m. (preceded by Tea in the Spit at 4.30 p.m.), when Professor H. R. B. Fenn, the President for 1947–8, will deliver his Presidential Address.

GUY'S HOSPITAL MEDICAL SCHOOL.

Applications are invited for the appointment of Demonstrator in the Anatomy Department as from the 1st October, 1947. Salary £550 per annum plus superannuation and family allowances. Forms of application obtainable from the Medical School Office to be submitted to the Dean not later than 30th September, 1947.

Applications are invited for the appointment of Medical Registrar (2 vacancies) as from 1st October, 1947. Salary £500 per annum. Forms of application obtainable from the Medical School Office to be submitted to the Dean not later than 30th September, 1947.

Applications are invited for the appointment of Lecturer in Pharmacology. Salary £650 per annum plus superannuation and family allowances. Forms of application obtainable from the Medical School Office to be submitted to the Dean not later than 30th September, 1947, together with the names of three referees. The appointment will date from 1st October, 1947, and will be for two years in the first instance.

CHANGE OF ADDRESS

Sir Gordon Covell, C.I.E., Major-Gen. I.M.S. (retired), Sunridge, Fairoak Lane, Oxshott, Surrey. (Tel.: 373.)

H. Colin Davis, L.D.S., 17, The Market Place, Devizes, Wilts. (Tel.: 50.)

PAPERS BY GUY'S MEN

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——. The early diagnosis of cancer of the œsophagus and stomach. *Brit. Med. J.*, 1947, ii, 405.

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Ryle, J. A. Social pathology and the new era in medicine. *Bull., New York Acad. Med.*, 1947, **23**, 312.

BIRTHS

CADMAN.—On August 29th, 1947, at Eddystone Nursing Home, to Margaret (née Tom Ruis-Russell), wife of A. E. Cadman, Surg.-Lt. (D.) R.N.—a son (John Richard).

DOY.—On September 14th, 1947, at Guy's Hospital, to Joan, wife of R. W. Doy—a son (Michael).

HARVEY.—On August 24th, 1947, at Mount Alvesnia, Guildford, to Sylvia, wife of Edward Harvey, L.D.S.—a daughter (Patricia Frances).

HOUSTON.—On September 9th, 1947, in Nuffield House, Guy's Hospital, to Thelma C. Houston, M.B., Ch.B., wife of James C. Houston, M.D., M.R.C.P.—a son.

NEWTON.—On September 18th, 1947, at Redhill County Hospital, to Joy (née Wright), wife of Dr. K. A. Newton—a daughter (Briding Jane).

OGLE.—On August 29th, 1947, at Barratt Maternity Hospital, to Beryl (née Thomas), wife of W. L. Ogle, 7, Gipsy Lane, Kettering—a daughter (Jane).

MARRIAGES

MARTINDALE—CORSON.—On August 22nd, 1947, at Badgeworth, nr. Cheltenham, Victor Horace Martindale, M.B., B.S., to Helen Corson, of Cambria, The Reddings, Cheltenham, Glos.

DEATHS

DUNSTAN.—On August 16th, 1947, Edward Dunstan, L.D.S., R.C.S., of 56, Warwick Avenue, Bedford, aged 35 years.

FLEETWOOD.—On July 5th, 1947, Leonard Montague Fleetwood. L.D.S., R.C.S., of Chichester, Sussex.

GOODEY.—On August 25th, 1947, Albert Goodey, L.D.S., R.C.S., of Halstead, Essex.

Eds. {D.H.F. H.A.R.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

" GENTLEMEN, THE LADIES " !

FOR nearly two and a quarter centuries our hospital has been producing doctors. Men of all colours, of all creeds, and from all social strata have studied at Guy's and, in addition to the fruits of their academic labours, have acquired that indefinable moulding to their character that constitutes a Guy's man. Two hundred and twenty-two years have rolled away and the brotherhood has remained, the shadow of woman lingering perhaps in the colonnade but never intruding itself to the scholastic chambers of the medical school. When the prospect of training women doctors and dentists at Guy's was first considered, contemptuous snorts were heard in the college and hostile feeling ran high. To-day, the inevitability of such a move has been accepted for totalitarianism has laid down its laws and the onslaught is being met with open minds.

We are invaded.

Amongst the group of new entries that we welcome to our hospital this year are to be found our first female students. They are only a few in number and they are doubtless crossing our threshold with as much trepidation as we feel who are here to greet them. We hope that they and their male colleagues will enjoy their life at Guy's as much as we do.

Naturally, certain minor alterations will have to be made to ensure the success of this co-educational scheme. As all the new female entries are pre-clinical students they will, for the time being, be spared the effort of trolley-pushing as surgical dressers and the embarrassment of the murals in the Externs' room as obstetric manipulators. Their present concern, apart from their academic pursuits, will be to get used to a series of useful but extremely rude rhymes whereby is aided the study of human anatomy, whilst they must needs listen, unblushingly, to those gentle oaths which are apt to leave the lips of the young bio-chemistry enthusiast when his test tube cracks to deposit its boiling contents of physiological fluid on his sensitive fingers.

We understand that they are to become members of the Clubs' Union. This should prove interesting and the first fifteens of the future may prove to be even more graceful than they are at present.

Many strange events seem destined to occur in future years and, whilst it may be very tempting to make facetious speculations on such happenings, it is a little disconcerting to think of each clinical appointment, out of deference to the ladies, being concluded, not with the customary carousal in a tavern, but with a cup of tea at Debenham and Freebody's and the presentation of a bunch of carnations to the consultant, whoever she may be at that time.

Several of the women students have already had training at Guy's, either as nurses or in the Physiotheraphy Department, and so they will not feel

completely strange in their work. We hope that they will help to make their colleagues feel at home and we are confident that all Guy's men will extend to these newcomers, male and female, the same goodwill as they have in the past

WE are pleased to publish the following news from the Dental representative of the *Gazette* Committee :—

"The Dental School is playing its part in fostering Anglo-American relations ; two members of the staff are already in the United States, one is en route, and one has recently returned. Mr. K. E. Pringle, Assistant Dental Surgeon to the Children's Department, has gone, under the auspices of the Dental School, for four months, to observe latest methods of treatment and research in orthodontics. It is hoped that he will have time to visit most of the Dental Schools in America.

Mr. G. J. Parfitt, Director of the Department of Preventive Dentistry, will shortly arrive in America to compare notes on the latest developments in all branches of Preventive Dentistry. Under the auspices of the Nuffield Foundation and the Dental School, he is to visit four schools in that country, and also the University of Toronto.

Mr. A. A. W. Fooks, former Resident Dental Officer, is in Chicago, having been awarded a Scholarship tenable at the North-Western University Dental School.

Mr. G. S. Loader, one of the staff Demonstrators, has recently returned from a Congress of the International Dental Federation in Boston, Massachusetts. This Congress, the first to be held since the war, was held in conjunction with the Annual General Meeting of the American Dental Association. About fifteen thousand dentists, representing forty-one nations, were present, of whom sixteen were British. He reports that the Americans maintained their reputation for warm hospitality to the visitors, and that the main trend in Dental Research over there seems to lie in the investigation of the rôle of Fluorine in preventing Dental Caries."

ON October 6th, at 3 p.m., the Medical School was officially opened at the beginning of the new university year. This was the first time this ceremony has been performed since 1938, and it is extremely pleasant to see the revival of such traditional events. The opening of the school was followed by a Prize Giving, at which Lord Greene, Master of the Rolls, distributed the prizes awarded during the past year.

ON September 30th, Dr. J. H. Ryffel, for many years Lecturer in Forensic Medicine and head of the Clinical Chemistry Department, retired from his position at the hospital. On behalf of our readers we wish him good fortune and every happiness in his well-earned retirement.

We congratulate the Students' Union on producing a small booklet, "Guy's," which is intended for new students. It contains general information about the hospital, the medical and dental syllabuses and student activities and will undoubtedly help the newcomer to find his way about the many departments of the medical school and wards.

WE hope to publish the list of new entries to the Medical School in the next issue of the *Gazette.*

The Doctor of the Near Future

By P.F.S.C.

BOSWELL, in his life of Samuel Johnson, said: "I believe every man has found in physicians great liberality and dignity of sentiment; very prompt effusions of beneficience and willingness to exert a lucrative art where there is no hope of lucre," and, no doubt, each of us in his reading has found everywhere like tributes from all ages which give us cause to be proud of those who have practised our science and art. It is to these men that we owe that feeling of goodwill and confidence with which patients come to us, perhaps much more than to our own personal qualities. To each one of us there comes through our training, through teachers who are in the direct line of these fine doctors of old and through our reading, much of the bounty that they have handed on in spirit, a spirit which still works strongly, so whatever changes there may be in the organisation of the profession, there is hope that the essential qualities of the good doctor will not be wiped out, even if the system be a beaurocratic one with its liability to stultification. We must, however, be keenly watchful of the danger and cherish the quickening power of individuality; a task which I think is not beyond the abilities of men of goodwill.

It is very recently that people have begun to think and realise that the health of the nation is more valuable than its prosperity, and this realisation is calling for a new kind of Doctor; one who prevents disease and is not much interested in individuals. In this he is different from the clinician who is a personal advisor and who, at his best, is often a friend, confessor and strong support in close contact with his patient, being deeply solicitious for his isolated welfare; often so occupied with the individual, that the masses become blurred, as it were, in the periphery of his mind's eye and fade from his concern.

Interested in individuals, he himself is an individualist who, in spite of excellent qualities, has many of the defects that go with individualism. He may be jealous of his opinions to the extent of an overwhelming vanity. He is intolerant of any restriction on his actions although they are sometimes whimsical. He is not always free of pomposity and exhibitionism, but the best of them are often so possessed of a warmth of heart and such humanity as to make them lovable in spite of their peccadilloes. Of a baser failing of the individualist, avaricious commercialism, which poisons the profession, we all know too much.

Specialisation is rapidly cutting clinical medicine into many parts, and therefore moving away from the trend which joined the Colleges of Physicians and Surgeons so that the ideal of a surgeon should be to reach the learning and skill of a physician using deft hands to cure disease. These changes seem to me to be pre-destined for, unless there is a sudden increase in brain power and capacity in the ordinary man, it is, and will be, more and more impossible for him to comprehend the immense sum of knowledge about healing and the prevention of disease that is being garnered in separated fields. The laboratory expert works miles away from the bedside and it is often difficult to reach him even by telephone. The Radiologist has no chance to verify his pronouncements. The general practitioner loses his interesting cases in the depth of a large and busy hospital where his visits are resented as intrusions.

Even in the hospital staff there are cramping divisions. We have all had experience of the cardiologist who forgets that the patients has a mind that can be injured by dark fears or the psychologist who misses the small specks of tuberculosis in the lung that are causing the unhinged mind. The list could be lengthened for pages and everyone of us has sinned in one category or another.

It seems that the solution may be found in the use of what has been called the " group mind." The term is, I think, a misnomer as I do not think it is a mind at all in the sense that the mind is something living. I would perfer to call it " the group mind instrument " (or perhaps a Greek scholar could suggest a more elegant and single word to cover the meaning); but neglecting terminology, there is no doubt that a committee of men with harmonious purpose often produce a more justly proportioned result than a single mind, inadequately equipped, can do. Team work medicine is already in being but is still tentative and immature. We have yet to learn its technique. I certainly do not think, for example, that patients should come to see a board of doctors if they get fever and a pain in the right iliac fossa. If decisions are always to be made by a group the results surely will be only average and brilliant men with the flair for diagnosis or other abilities are likely to be flattened. But the instrument should always be available and personal vanity so much discountenanced that frequent recourse to this instrument be taken: perhaps its greatest value will be realised in the kind of conference that is held at the Mayo Clinic, sometimes round the Post Mortem table and more often after the findings at the operation are available, or when the patient is discharged. Valuable as such a group is, I would insist that the final responsibility and decision be vested in one man.

A technique for these conferences must be perfected: we all know the tedious man who loves to hear his own voice and meanders on in senseless jargoning, the man with fads or the masterful man whose joy it is to dominate the meeting; the impatient man or the wag who likes, to shatter the train of thought with facetiousness. They are difficult to deal with, but a good chairman should be able to do so. Another and greater difficulty is that conferences take up so much time and unless their quality is high they will be dodged. Geographical considerations are important: there is something to be said for streets of doctors, apart from their prestige and money value, as there is much less disinclination to foregather if the place of meeting is conveniently near, so dwellings of doctors will, I foresee, be grouped round Health Centres. This is against the natural desire to live away from one's work, but it seems to me to be a sacrifice that must be made for the purpose of cultivating something of the collegiate spirit with all its benefits.

The good Clinician is seldom a good administrator. It is his task to deal with the individual for whom he often develops a friendly care that outweighs the administrator's guiding principle of " the greatest good for the greatest number," which, although it is broadly satisfactory, has all the failings of schemes based on statistical averages and does not allow for the more compassionate principle of " to each according of his needs and from each according to his abilities," for the details of its application often cause impatience in the administrator, far away from stark, disease-racked human beings. He finds it hard to understand why a 3rd class patient should sometimes need a quiet room to himself when his status entitles him to a general ward, or why one surgeon demands a different kind of surgical instrument from another for the

same operation. Or why the cost of treating an illness should suddenly go up when a new effective drug comes in, and is perturbed by the big cost of the previous drug which it has supplanted, and that it should be wasted in its disuse. He does sometimes understand these things when they are explained to him, but they are not immediately apparent and there is usually some reluctance to comply.

Perhaps the difference between the administrator and the clinician can be drawn in these two attitudes of mind. The clinician feels that " My patient should come first," while the administrator is concerned about the reduction of the incidence of disease, with the minimum expense.

It seems that in a scheme of state medicine (and most are now agreed that this organisation is both inevitable and desirable, despite its defects), we as clinicians will have to make the vast sacrifice of our sovereign rights, as it must mean that clinical medicine becomes a subdivision of Public Health. Where then shall we find our administrators ? The man who has spent the best days of his life in the delight of gaining skill in a craft and art is not attracted by the prospect of spending his years of seniority at an office desk, unless he is lured by higher salary and pension—a powerful lure if he has a big family to educate. This is discouraging to the clinician as he soon realises that advancement, after a time, is only through the avenue of administration. This defect exists in all the public medical services at present—the R.A.M.C., the Navy and the Colonial Medical Service. There is a remedy I think in delegating a reasonable amount of autonomy to the clinicians under the broad control of the administrators, who will be concerned with managerial duty from their most junior years, but, in their sphere, the clinicians must be enabled to reach posts equal in value to those of the Public Health Officers, from whom will come the administrators, and, if they go through the course of education, which I shall subsequently outline, they will not be unversed in the needs and aspirations of the clinicians.

Whether the State takes control of Medicine or not, I foresee great changes in medical education. The present teaching of doctors is entirely in the hands of specialists of consulting status—who give a lopsided view of medicine to students. They stir the imagination and enthusiasm of young men for the unusual diseases and for the spectacular and complicated treatments and operations, implanting at the same time more than a tinge of disdain for the Family Doctor—a better name, I think, than General Practitioner. These specialists are apt to be remote from what Professor John Ryle has called the Natural History of Disease, for illness is presented to them in neat hospital beds, in elegant consulting rooms or for a brief time in the more wealthy homes, and almost always when it is established firmly.

Furthermore, rarity overjoys them with the gust of a collector of old masters, and this spirit soon is woven in to the fabric of students. I have often noticed how difficult it is to interest them in the details of an erosion of the cervix, while they revel in the description of a granulosa celled neoplasm of the ovary. They are bored by septic fingers but relish the details of transplantation of the ureters.

This theme is hackneyed but as yet nothing has been done about it and in considering any changes one must re-state the case to see how they may be brought about.

T. B. Layton wrote a very stimulating paper just before the war. In it he outlined a syllabus which dealt with these points. He would have a basic education, not lengthened in time, but cutting out much technical detail and rather training the students to think in terms of method, clinical instruction being started much earlier than now, so that the practical details of the more abstract scientific subject of anatomy, physiology and bio-chemistry can be appreciated early. At the end of this period a degree would be taken, after which further education would be continued, with pay, in the special branches. It is unnecessary, according to him, for an obstetrician to have a minute memory knowledge of bacteriology or for a bacteriologist to have a detailed similar knowledge, with small skill in obstetric manœuvres. Nor does a physician need to know the fine points of a radical mastoid operation. These should be learned specially during an apprenticeship to masters of the craft.

There would thus be for the whole country a qualifying examination of the M.B., B.Ch. standard, not qualifying for independent practice, but acting as a portal to the specialisms. The final examinations would be an M.D. which could be taken in one of several branches, for example, General Medicine, State Medicine, Psychological Medicine, Bacteriology and Pathology, Family Medicine, Radiology.

An M.S. in General Surgery, Ear, Nose and Throat Surgery, Eye Diseases, Obstetrics and Gynæcology.

If I may add my opinion, gleaned mostly from others' criticism, I would suggest an extension, assuming an entirely state organisation of Medicine. After taking the basic examination there should be a compulsoty period of one year in which both the appointment of H.S. and H.P. would be done in a general hospital, to give experience, under guidance of the grave emergencies of medicine, after which, unless Bacteriology and Pathology or Radiology were chosen as specialisms, everyone would have to do one year of Family Medicine under the apprenticeship of the specialist in Family Medicine. I again emphasise this title. It is time that a high valuation of those who are being unjustly disparaged by both the profession and the public is reinstated. The character of the old family practitioner is being smothered, and yet the disposition which grows to this kind of manhood must be reborn many times in each generation, when it only needs cultivation for its full growth to take place. The Greeks recognised it in their days of perspicacity, as this description of the young Asklepios, later the father of medicine, shows. It is taken from Kingsley's Heroes: "Only one waited apart and silent, Asklepios the too wise child, with his bosom full of herbs and flowers and round his wrist a spotted snake; he came with downcast eyes to Cheiron and whispered how he had watched the snake cast its old skin and grow young again before his eyes and how he had gone down into a village and cured a dying man with a herb which he had seen a sick goat eat.

And Cheiron smiled and said, "To each Athene and Apollo give some gifts and each is worthy in his place; but to this child they have given an honour beyond all honours, to cure while others kill."

This important branch of medicine requires very special qualities of mind, characters and ability and there is a tendency to relegate it to the less brilliant men. It should be here, under the best masters, that the apprentice should learn about disease in its natural environment and if he is not worked to utter fatigue, as the present assistant on £300 a year as a rule is, he will, if he is

temperamentally suited, often continue in this branch taking his M.D. in the subject with the same eagerness as he would in any other. If he inclines to another branch, this year will never be a wasted one, and if the conditions and opportunities are equal in Family Medicine to those in other branches, many will take it up with a vocational enthusiasm, for I feel that there are numerous men to whom the study and rich human relationships, which come when working with and aiding human beings in their natural surroundings, will be most satisfying. After this period of a year, or possibly more, any other branch may be chosen.

Some of the prominent advantages of a State organisation are that it provides reasonable leisure and holidays, and adequate minimum of financial security, pension and encouragement for post graduate study.

To turn from personnel to hospitals, independent cottage hospitals first come to mind and they are in my experience far below standard. They are inadequately equipped, badly staffed, and offer temptation to the occasional surgeon to try operations beyond his ability, so that he may strut in vain glory as the hero who saved Mrs. Jones's life by brilliant use of the knife. I foresee them being run as branches of centralised hospital of some size, and for the convenience of the Family Doctor. All Laboratory work and most X-ray work could be carried out in the Central hospital, while swift moving and smooth running motor ambulances can take the surgical emergencies to the Central Hospital. It is at the Central Hospital that the organisation of the region will be controlled.

This brings us again to the problem of the administrator. There seems to be a serious shortage of this kind of man in the world. The task before him becomes more and more complicated and needs qualities of intuitive knowledge and generous hearted wisdom too uncommon. He needs something akin to the sweet reasonablenessand tact of a clever and kindly but firm mother with her unruly family, but must *not* be an " old woman." Men of this sort do exist and must be cultivated. In medicine most administrators will certainly be drawn from the Public Health Services, but no doubt many clinicians, as they grow older, will be inclined to leave the strain of hard rough and tumble for the more equable life of organising. They should by no means be excluded, and always there must be opportunities for the clinicians to have say in their government, even though they be relieved of its routine.

Assuming the figurative Cæsar to be wholly mindful of the welfare of the State, but of necessity only in broad principles it is in the main the administrators' part (being, as they are, to a great extent legislators) to look to it that those things are rendered unto Cæsar which are Cæsar's while it is for the Clinician also, to render unto Cæsar those things which are Cæsar's, *but* to render compassionately unto his patient, *his due*.

The research worker is concerned neither much with Cæsar nor with patients but almost alone with Truth as he conceives it. It is, to my mind, the problem which lies before us to synthesise these trends into a sound and smooth-working system, fostering in it the best traditions of the past. With this intention I see no reason why the profession should not continue to produce many men like Dr. Arbuthnot, of whom Samuel Johnson said : " He was the first man among them. He was the most universal genius, being an excellent physician, a man of deep learning and a man of much humour."

I anticipate a wide increase in Research but with closer organisation, and a more stringent scrutiny of published papers, which are seldom subjected to the criticism of a trained statistician who is qualified to weigh their significance. So much, too, is haphazard and done for the purpose of self-advertisement. I suppose the preliminary report has some value, apart from the pegging of a claim to be first in the field, but they are unsatisfying and smack of the journalistic " scoop."

There is need of two kinds of men in this specialism : the man of imagination and intuitive ideas but who is sometimes short of the patience needful to prove or disprove his flashes of genius, and the type who may be called, as Huxley said of Philip Gosse, " the honest hodmen of science." These people are trained in the methods of science, and with persevering and conscientious zeal work out and check the results of the initiators. There will have to be posts for many of these, and women are more often suited to this labour than men. The initiator, the man of inspirational genius, is rare and great trouble should be taken to find him. When found, he has often to be pampered and humoured in a way which the routine administrator finds difficult, as the man of genius is by nature self-willed and often has a singleness of mind that is almost fanatical. This theme is admirably pictured in Morgan's essay and play, " The Flashing Stream," which impressed me deeply.

ROUTINE EXAMINATIONS.

Another branch of medicine that is sparsely developed is the routine periodical examination for everybody. The beginnings of this are apparent but its growth is tediously slow in spite of its obvious benefits.

Many insurance companies in America will give a reduced rate of premium if the policy holder consents to visit the companies own physician, free of charge, for regular overhaul. In the Air Force it is found essential to re-examine pilots with frequent regularity and school children are now medically inspected as a routine—but for adults there is nothing.

There is no doubt that a decade or so of such examinations would not only pay financially, but would also reveal a wide new realm of signs and symptoms of early disease—disease when it is most easily cured.

There seem to be mainly two factors which work against this scheme. The first is the reluctance of the ordinary person to submit to the examination. This is, I think, mostly due to the fear of what may be discovered and is likely to lessen if the school days' examination gives a sense of confidence in it. The second is that these routine examinations tend to be dull and lengthy—and this is the doctors deterrent. Lengthy they must be, if they are to have value—as, it seems to me, the most difficult diagnosis to make in medicine is " Normal Man." Furthermore, to make it statistically valuable, the smallest details of early disease must be sought for and recorded with the closest attention and alertness. This type of work calls for something like the chartered accountant's mental disposition and such men will have to be encouraged in the profession. They will be more concerned with elucidating than with tinkering and adjusting or preventing, and to the rightly selected kind of men this work should not be dull. This sphere should also be well suited to women especially as it can easily be arranged as part-time work.

To touch on mundane but important matters, namely, those of pay and promotion : I think all will agree that few men are sufficiently devoted to

work for the reward of achievement only, and furthermore, there will always be a proportion of loafers, so I foresee some such plan as this. Promotion will not be solely by seniority, but ability will always override it, and a basic rate of pay will be given. This will be adequate but will mean a living with frugality. In proportion to the amount of work and to its quality there will be increases of substantial enough amounts to be strongly encouraging.

Fitting in with this the patient will be enabled to have a choice of doctor on the principle of the present panel system.

Free lance doctors and nursing homes will not be prohibited but it seems likely they will find in time that they cannot compete.

In a series of articles entitled " Motives and Mechanisms of the Mind," published by *The Lancet*, there is one which analyses the fundamental drives of the mind. The substance of this article I can only quote from memory. The writer of it, with perhaps over-simplification for the purpose of clarity, postulates three fundamental urges in the mind, the first of which is the desire for power, the second for security, and the third for affection. These are considered to exist in varying proportions in different men, sometimes harmoniously balanced, sometimes jangling disastrously and sometimes one or other becomes a depraved lust, but although any one of these may outweigh the others, within the restraint of decency, it can be a force of untold value. Remembering this when I review the scheme which I have attempted to outline, one fear sticks deep, and that is of the power-glutton, the man who is greedy to impose his personality and ideas on the whole organisation. He does not recognise that initiative is not far removed from eccentricity and what good-will towards men that he has is distilled into fumes of statistics, showing reduced incidence of disease. They often do work towards an ultimate good, but in doing so are liable to obliterate much of essential value. This must be the wickedness against which the administrator should guard, if he is not to exterminate the kind of doctor of whom a Roman poet said :—

> " It was his part to study the nature of medicines and the manner of healing and regardless of glory to practice this quiet art."

To Those About to Enter the Medical Wards

By Sir JOHN CONYBEARE, K.B.E., F.R.C.P.

SINCE the institution of the Preliminary Clinical Period about fifteen years ago, students starting their ward work as first three-month medical ward clerks are already familiar with the routine methods of examination and have some knowledge, perhaps mainly theoretical, of physical signs. They have also had some instruction in clinical pathology and are in a position to realise that in certain types of case pathological investigations play an essential part in diagnosis.

There are, however, very real differences between the patients seen in the Preclinical Classroom and those who are in the beds in the medical wards. The former are relatively fit and come up to be examined because thay have well marked physical signs. Moreover, they are paid to come up and are prepared for any amount of examination. The ward patients, on the other hand, have entered the hospital, not as material for students to examine, but because they are ill and in need of treatment. Moreover, far from being paid to come in many of them are paying directly or indirectly for their treatment in hospital.

Students in the preliminary clinical period naturally take but scanty interest in the patients they examine, except in so far as they are good examples of an objective lesion, whether it be mitral stenosis, a fibroid lung, or a lump in the belly. In the patient as a whole they are not greatly interested.

On entering the medical wards the relationship between student and patient is of quite a different order. The ward clerk should now regard himself as almost the family doctor to his patients. He must be familiar with every aspect of their case and with all the factors, economic, domestic and social, which have a bearing on their illness. The ward clerk is often able to obtain the confidence of his patient more completely than can even the House Physician and he is, therefore, in a position in which he can help to allay apprehension and anxiety.

Before further discussion of the value of the appointment of medical ward clerk it is perhaps appropriate here to stress a few practical points.

In the first place students should realise that the Governors have laid down that the wards shall be closed to students before 10.0 a.m., between 12.30 and 1.30 p.m., and between 4.0 and 4.45 p.m., and after 7.0 p.m. In other words the wards are open all day except for two relatively short periods. This does not, however, mean that any individual patient is available for examination at any particular moment. The patient may be being washed or fed and needless to say the ward clerk will co-operate with the nursing staff in so timing his examinations that they do not clash with nursing duties.

The ward clerk is responsible for the ward report. May I urge him to be particularly careful to fill up the details on the front page, giving the patient's full name and address, the name and address of his doctor and other important details. It is always possible that at a later date someone may want to follow up the case and nothing is more infuriating than to find relevant information missing owing to the carelessness of a ward clerk.

Students have only six months of clerkship in the medical wards, which compare with nine months of general surgery. These six months are probably the most important in the whole of the medical curriculum. It is only during this period that the student has real and unrestricted access to patients. True he can go on ward rounds at later periods but he is then a "foreign body," who will have little or no opportunity of examining a patient. It is, therefore, most important that every medical ward clerk should make full use of his opportunities of clinical study of cases and nothing should be allowed to interfere with this object.

Books can be read at any time but the opportunities for obtaining clinical experience of cases is limited. Therefore never waste time in reading at a time when you might be seeing cases. During the medical ward clerk appointment no attempt should be made to read medicine systematically. It is far better to read up the text-book accounts of diseases which you have encountered in the wards. If possible, read them up in more than one book and see how the text-book descriptions fit in with the cases you actually see.

During six months as a medical ward clerk you will have seen examples of practically every medical condition which is frequent or important. Some of the rarities you may not happen to encounter, for instance Addison's disease or hæmochromatosis, but the great majority of diseases you will have seen. If these have been read up there will not be very great deficiencies in your text-book knowledge at the end of six months.

There is, however, a proviso to what has been said above. Though the patients in your own beds are your special charge and responsibility, it is equally important that you should be familiar with cases in the beds allocated to your fellow ward clerks. Though you are not responsible for their ward reports you should certainly know the full history and details of every case in the ward, and if the patient has abnormal physical signs you should have examined him preferably in association with his own ward clerk. In other words, knowledge of your own cases is not enough. You must know every case in the beds allocated to the firm and be personally familiar with any physical signs that are present.

If any of your own patients need some special examination, whether it be a lumbar puncture, a blood transfusion, a bronchoscopy, or an aspiration, it is your duty and privilege to be present and the responsibility for finding out the time and place is yours. Hence it is important to keep close and friendly relations with the house physician and the nursing staff. If you are a constant attendant on these occasions at the worst you will get a first-hand demonstration of what is being done, at the best you may be allowed to perform the operation yourself under supervision.

It is also advisable to keep in touch with your friends on other medical firms. By so doing you may be enabled to see cases of special interest or rarity.

Cases you have seen during your period as medical ward clerks are going to form the basis of your knowledge of medicine. There is much to be said for keeping personal notes of the interesting cases you see, either on some form of card or in a loose-leaf note book. You can then index the cases by diseases and of course add to your collection such cases as you encounter later. Notes of this kind are of great value, especially if they include the comments of registrars and members of the staff who have seen the patient.

Your period as a medical ward clerk is that in which you should acquire a real familiarity with physical signs. In spite of the great advances in accessory aids to diagnosis, such as X-rays, physical signs are still important and significant, though it must be admitted that absence of abnormal physical signs means little or nothing.

Unfortunately, physical signs are difficult and can be learnt not from books but only from assiduous personal experience. Though you may have been taught something about physical signs in the preliminary clinical period class, it is during your six months as a ward clerk that your real opportunities for learning murmurs and other physical signs in the chest are available. If you fail to make use of them it is going to be extremely difficult to find similar opportunities at a later date. Remember, too, that even from the purely material point of view of success in examinations a failure to recognise an aortic or mitral murmur will quite rightly often lead to failure. Therefore take every possible opportunity of listening to hearts and lungs, not in the rush of ward rounds but at quiet times, for instance, after tea.

During the last few months arrangements have been made for medical ward clerks to have a "take-in," comparable to that of dressers on the surgical side. This innovation will give the "take-in" clerks an opportunity of seeing medical emergencies immediately on their admission to hospital. In order to obtain full value from this period of residence it is essential for the "take-in" ward clerk to be immediately available and to keep in close touch with his house physician.

It is also the duty of medical ward clerks to be present at medical out-patients. Here they have unequalled opportunities of examining patients and trying to arrive at a provisional diagnosis. In return they should make certain that the urine is examined in every case and adequate notes made in the out-patient letter. A keen and intelligent firm can greatly lighten the task of the physician.

To Those About to Enter the Surgical Wards

By H. J. B. ATKINS, D.M., M.Ch.(Oxon.), F.R.C.S.

FIRST let me extend to you a very warm welcome. After years of preparation you are now ready to start playing your part in the real job of a doctor's life—to help his patients to get well. At first you may find that the atmosphere of the wards is strange after that of the medical school, and it will take you a little time before you feel at home there. When you were in the medical school you were the centre of attraction, the very buildings were erected for the express purpose of housing you, and the activities of the entire institution were directed for your benefit; now that you are in the wards you will have to take second place to the patients. The wards were not built for you, but for the patients; the nursing staff are not primarily interested in your education (though they will often do a lot to help you) but in the patients, and it is in the constant service of your patients that you will, almost incidentally, absorb that knowledge and skill which will make you a good doctor—honest, sensible, practical and keen, in fact everything that we like to think implied by the title—"a Guy's man."

What a pity we cannot revive the old expression, "walking the wards." Nowadays, I fear, the student's career would be more fittingly described as "sitting the lecture theatre." Spend all the time you can in the wards and at Out-Patients and see and do everything that you can yourself. Don't think that you will have a better chance of passing your examinations if you spend hours reading that should be devoted to clinical work.

Although in the last analysis you can only learn clinical surgery through your own efforts, you will nevertheless receive plenty of instruction. The good doctor must be able to think for himself, but in order to think profitably about surgical matters and not to indulge in dangerous theorising it is necessary to be in possession of facts.

A part of your education will therefore consist in factual teaching. This is usually done by the registrar to your firm who will at the same time take pains to see that you know how to examine a case properly and to elicit physical signs with confidence. For the most part the registrar will lead you from the particular to the general; "here is a case of acute appendicitis, let us see what we can learn about acute appendicitis in general taking this particular case as a context." On the other hand, you will also receive teaching from members of the staff. This teaching should be, and usually is, different in type. In the first place it would be redundant for the consultant to go over in the afternoon the same ground which has been covered by the registrar in the morning; in the second place, those attending these rounds are at different levels of surgical education, and lastly, the member of the staff should be able in virtue of his seniority to communicate, from his store of experience, knowledge which is not to be found in the books. These rounds proceed usually from the general to the particular. The individual problems of the particular patient are discussed, the case is analysed in greater detail and the result is an essential complement to the systematic teaching of the registrar. It is not, however, alone by what they tell you that you will learn from the senior members of the staff. Sir Arbuthnot Lane was in many ways a great surgical teacher, though he rarely indulged in what would commonly be regarded as academic teaching. There is such a thing as teaching by precept and you will learn much by quiet observation. Observe how a surgeon twenty or thirty years your senior will spend three times as long as you did over taking the history of a patient and in his clinical examination before he presumes to make a diagnosis. Remember what points in the history he elicited and which were significant, what physical signs he found and to which he paid the greatest attention. Try to follow the mental processes involved in solving a difficult diagnostic problem and then apply these methods to your own problems.

Now let us consider the vexed question of time spent in the operating theatre. As a student I spent long hours standing first on one leg and then on the other watching operations, the details of which were quite beyond me and which the majority of my contemporaries would never perform. I became the most enthusiastic advocate of the "banish the students from the theatre" movement which is being pursued so actively to-day. Nevertheless, I believe that the pendulum may swing too far the other way. It is part of every doctor's education to know the ritual of asepsis, to see what surgery can do, to appreciate the difficulties, and above all to catch something of that spirit of strenuous, disciplined endeavour which is the atmosphere of the operating theatre. There more than anywhere else you will learn to appreciate the grave responsibilities of your calling. In the theatre, too, you will be able to study what Lord Moynihan termed "the pathology of the living," and you will be able to interpret with startling clarity the value of your physical signs, to be heartened by your correct diagnoses and to learn from your mistakes. That, incidentally, you may have to act as a porter means that you are for the first time learning that a doctor's duty consists not infrequently in putting himself to some personal inconvenience and bodily exertion to be of practical service to his patients.

You must undoubtedly attend when your own cases are being operated upon in order that the notes of the operation may be written intelligently. When you do this you will probably be allowed to "wash up" and the complicated details of modern asepsis will be explained to you. Furthermore, when you are "washed up" you will be able to stand up to the table and get a really good view of what is going on. Otherwise I should advise you to attend in the theatre whenever an operation is being performed which you have not seen before, and always where shortage of porters would otherwise entail lifting and heavy work on the part of the nursing staff whose duties it should be your constant endeavour to lighten.

As surgery becomes more and more professional in its exacting demands, there is an increasing tendency to relegate all but a few privileged spectators to the balcony, so that much of your watching will be done from there. Nevertheless, you will often be in the body of the theatre, and I propose, therefore, to say a word about theatre manners. If you are "washed up," remember that everything, including the skirt of your "sterile" gown, below the waist must be considered unsterile. Keep your hands high therefore and away from any possibility of contamination. If you are not "washed up" wear a bandage as a belt round your gown so that it does not billow, and give every person or article which is sterile a wide berth. You may see a hundred operations run smoothly, but sooner or later you will witness a tragedy. If it is only the thousandth case, remember that that thousandth is somebody's father, or wife, or child and you want to be quite sure that by your demeanour and conduct you have

not in the slightest degree contributed to the tragedy. In the theatre "silence is golden." There is nothing more distracting to the surgeon than to half hear a whispered conversation at the back of the theatre. You would not do it on the eighteenth green when you are watching the crucial three-yard put that was to win the Open Championship; don't do it in the theatre where the results are not so publicised but are of greater consequence.

At all times do what you can for visitors to the hospital. When you go abroad you will find that, however lowly your status, you will be treated by world-famous surgeons and professors with that deference and consideration due to a visitor. In England we have a bad reputation for indifference in this respect, and it is up to us all to exercise this spirit. Greet a medical visitor to the hospital as you would a guest in your own house. See that he is directed to where he wishes to go, if possible accompanying him yourself; in the theatre make sure that he is provided with cap, gown and mask, and that he is so placed that he can get an uninterrupted view of the operation which he may have travelled three thousand miles to see. Inform the surgeon who is operating that there is a visitor in the theatre and if possible give his name; arrange for him to take tea or coffee, and in fact treat him as the friend which, within the freemasonry of medicine, he undoubtedly is.

Finally, remember that you are an integral part of a world famous hospital, that you are a Guy's man and that the reputation of Guy's is in your hands. I believe that this hospital is moving to a period of greatness and you are privileged to be participators. Work as you have never worked before, keep faith with yourself and do your best. Now "*au revoir*," and good luck.

To Those About to Enter the Dental School

BY F. S. WARNER, L.R.C.P., M.R.C.S., F.D.S.

THE Dental School extends a hearty welcome to you, the men and women students who are commencing your studies at Guy's this year. You are joining a Hospital and School which is noted for the *esprit de corps* which exists among its students and among the many qualified Guy's men who are in practice all over the world. You will soon be imbued with this spirit, the Guy's spirit, which makes the working of both Hospital and School run on such harmonious lines, and which binds all Guy's men together wherever they may be.

You are embarking upon a course of training which needs hard work and concentration, but which will hold your interest throughout if you have chosen your profession wisely. In the early stages you will study chemistry, physics and biology, followed by anatomy and physiology—the fundamental sciences upon which the understanding of your word depends. Then comes dental mechanics and prosthetics, and your first contact with Hospital patients. This provides your first opportunity to develop that professional manner and bearing which are so essential after qualification and without which nobody, however capable, can hope to be successful in practice. Clinical work fills the next two years—you will find that Guy's offers you every possible opportunity to obtain clinical and operative experience. Whatever else happens, do not fail to grasp this opportunity.

Now for a few words of advice—work hard but participate in the sporting and social activities of the Hospital and School—attend the monthly meetings of the Dental Society and take part in the discussions, and—finally—seek the help of your teachers on any aspect of your work about which you are worried. Remember that the members of the Staff are always pleased to try and help you.

The Dean, the Sub-Dean and the officials in the Medical School Office are there to discuss with you any difficulty you may experience in your course of study, and to give you any advice which may be of assistance to you. Do not hesitate to consult them if you wish to do so.

You will enjoy your time at Guy's. Good luck to all of you.

Student Health Service

By W. N. MANN

A STUDENT Health Service was originally started at Guy's before the war. It was necessarily interrupted, but it now in its third post-war year.

The object of the scheme is primarily to maintain the health of students and to use the resources of the hospital to the best advantage, both in the early treatment of disease and in the remedy of existing defects.

The following are the present arrangements :—

(1) All students are medically examined during their first year in the School and an X-ray examination is made of the chest. Should any condition be found for which treatment is desirable, the student is referred to the department of the hospital where this can best be carried out, or arrangements are made for this student to be seen again as should be necessary.

(2) Further X-ray examinations are carried out every year, or at more frequent intervals where this is considered advisable in individual cases.

(3) Before entering the wards, students are Schick-tested and those who are not immune to diphtheria are given protective inoculation. In addition a Mantoux test is carried out. If this indicates susceptibility to tuberculous infection, further tests are carried out and X-ray examinations arranged at intervals not exceeding six months.

(4) A special Out-Patient Clinic is held every Saturday morning at 10 a.m. Any student who desires medical advice may attend. He will be seen by one of the medical registrars and, should it be necessary, he will be referred for the further opinion of a member of the Visiting Staff.

(5) Confidential records are kept of these examinations and also of any illnesses treated at Guy's or elsewhere.

It will be appreciated that the number of routine examinations involved each year in carrying out this programme is very large. Thus about a thousand X-ray examinations have been made on behalf of the Service each year and over 500 medical examinations and consultations held. All examinations are made by appointment so that there shall be as little waiting as possible; lists of appointments are posted on the special notice board at the entrance to the Medical School, in the Dental School and in the College. In addition, students are individually informed of their appointments by letters placed in the rack in the Colonnade. In order that the Service may work smoothly and to the best advantage of those taking part, it is important that appointments should be kept. Where the appointment is at an unsuitable time, the secretary to the Health Service will be pleased to change it if adequate notice be given (Tel.: Hop 3500 Ext. 15 or 297 on the internal system).

It is only if full use of the Service be made by everyone that the Service can really be a success. During the past year a great deal has been achieved; advice has been given to a large number of students and cases of tuberculosis have been detected in an early and favourable stage. It is hoped that all students will take part in the Service to ensure the best preservation of their own health and that of the community to which they belong.

Guy's Hospital Clubs' Union

THE Handbook of the Clubs' Union in which full details of its many activities are recorded is available in the Medical School Office and only a brief note will be given here.

The Clubs' Union was formed in 1891 by the amalgamation of the various constituent Clubs and Societies the objects of this Union being to further, by their mutual support, the interests of these organisations, and to simplify the collection of subscriptions. By payment of one annual subscription a student becomes a member of all Clubs and Societies affiliated to the Clubs' Union and is furthermore entitled to a copy of the *Guy's Hospital Gazette* which is published fortnightly.

The premises of the Students' Club were damaged considerably during the war. The old " Spit " has however been redecorated and with the adjoining one-time Pavy Gymnasium has now been opened to provide an additional restaurant.

Two Squash Courts and the New Pavy Gymnasium are available at the Hospital, and there are excellent facilities at the Guy's Hospital Athletic Ground at Honor Oak Park.

The affairs of the Clubs' Union are managed by a Council of twenty-five. Of these six are members of the Hospital and School Staff and are elected annually at a School Council; seven are members of the Hospital and School Junior Staff elected annually by the Junior Staff Committee. The remaining twelve members of the Council are students elected in a manner which ensures the adequate representation of all constituent Clubs and Societies.

The Clubs' Union Council acts as a trustee for members subscriptions and each year allots funds in fair proportion to each constituent Club.

The Council meets four times a year, but extra meetings are held from time to time.

All students are advised to read the Clubs' Union Handbook for further details.

Below is a list of Constituent Clubs with dates of foundation :—

AFFILIATED.

Athletic Club	1860	Fencing Club	
Cricket Club		Pavy Gymnasium	
Debating Society	1892	Theatre Club	1945
Dental Society	1894	Music Club	
Rugby Football Club	1843	Students' Union	1941
Association Football Club	1882	Hockey Club	
Golf Society	1903	Lawn Tennis Club	1888
Sailing Club		Physical Society	1830
Students' Club	1882	Rifle Club	1883
Swimming Club		Boat Club	
Boxing Club		Ice Hockey Club	

NON-AFFILIATED.

Christian Union	1847	Musical and Operatic Society	
Physiological Society			

G. D. CHANNELL,
Hon. Sec. Clubs' Union.

To Those Entering the Nurses' School

BY H. M. GRATION.

TO the student Nurses who are just entering their training at Guy's, we are glad to have this opportunity of saying "WELCOME." We hope that you will find your four years at Guy's happy and interesting.

The life of the nurse in training has many sides. There is the practical experience in handling patients and making them comfortable, the learning of techniques, the use of apparatus and the administration of drugs, the assisting of the doctors in their clinical work in the wards. There is no doubt, however, that, apart from completing the syllabus of training, the most important function of a nurse is to create a happy atmosphere in the wards. Patients and medical staff, visitors, and in fact all who enter the ward will appreciate this, and it is the nursing staff who are almost entirely responsible for it.

"GOOD LUCK" to you all, and may your cheeriness and helpfulness make the wards at Guy's peaceful and happy places of recovery.

Correspondence

Over-Study

SIR,—The "chronics" that hang about medical schools for years are no doubt produced in several ways—laziness, drink, sport and, of course, sometimes ineptitude. There is another cause—overstudy. It is possible to be too keen. Let me relate my own case as a warning to the too studious. At school I took all the prizes for class work, and passed matric and the scientific in the first division. Then I began to read furiously for the medical exams. I was at it night and day, and got stale. At exams I made the most stupid mistakes. I remember at a *viva* when asked what acid I would use, I said "Oh, any—carbolic," although I knew quite well that it was an alcohol and not an acid. I had stuffed my head cram full of everything right up to the hour of exam.

So I continually failed to pass. I think I never would have got through the final M.B. if I had not taken several locums and so had a rest. We should remember the proverb: "All work and no play, makes Jack a dull boy." It is certainly a fact that one can be too conscientious and overdo it. One should do all the practical work possible, and keep the mind clear and active for reading. We know that over-feeding will cause indigestion, so over-study will dull the mind. There may be some who should be warned.

I am, etc.,

North Auckland, New Zealand. E. S. DUKES.

Tetanus Prophylaxis

SIR,—I would not dare pronounce upon the treatment of Tetanus, however upon reading a letter on this subject in the *Gazette*, (13-9-47), the last two cases that I have had to treat would appear to have presented an unusual feature. Neither of them had skin abrasions large enough to induce even the most adoring mother to bring them to Front Surgery, or anywhere else. One child died; early prophylactic antitoxin might have saved his life.

I am, etc.,

14, Faraday Mansions, Queens Club Gardens, W.14. DAVID P. NICHOLSON.

Students' Union

SIR,—Whilst fully aware of the good offices of the Students' Union in arranging the recent talk by Professor Blalock on "Shock," I would like to register a protest at what I and several others deemed a breach of good manners on the part of the Students' Union.

At the close of his lecture, Professor Blalock indicated that he was willing to answer any questions that the audience put to him in spite of the fact that his time was limited.

At this precise moment it was considered opportune to announce subsequent lectures and talks, thus reducing the discussion to the level of a cinema show where forthcoming attractions are announced during the interval.

I would suggest that the interval between the close of the lecture proper and the possible answering of questions was not, in fact, the end of the proceedings and that it would have been more seemly to have waited for a few moments to see whether any questions were forthcoming and then to have made any announcement considered necessary. It is a small point, but, I think, worth considering in these days when manners appear to be at a discount.

I am, etc.,

Guy's Hospital, S.E.1. W. W. THOMPSON.

Hospital Information, etc.

NOTICES

DEPARTMENT OF SURGERY.

On Saturday, 11th October, Mr. Philip Mitchiner of St. Thomas's Hospital will conduct a Departmental Round in Queen Ward at 10 a.m.

On Tuesday, 14th October, there will be a further demonstration in the series "Operative Procedure" in Theatre 3 at mid-day.

On Monday, 20th October, a complete film of Dr. Blalock's operation for Pulmonary Stenosis will be shown in the Anatomy Theatre at 5.30 p.m., and Guy's men who have not had an opportunity of seeing this film are especially welcome.

The Clinico-pathological meeting due to be held on Saturday, 25th October, has been postponed for one week, and will take place in the Anatomy Theatre on Saturday, 1st November, at 10.30 a.m.

An Exhibition illustrative of "Dysphagia" is being held in the Gordon Museum.

DEPARTMENT OF MEDICINE

Dr. P. M. F. Bishop will conduct a Combined Round on cases with Endocrine disease at 2.15 p.m. on Friday, 17th October, 1947, in the Pre-Clinical Classroom.

RUGGER DANCE.

There are still a few tickets left for the Annual Rugger Dance, to be held at the Hyde Park Hotel, Knightsbridge, on Wednesday, October 29th.

Dancing 9—2 a.m.

Tickets 50*s*. (Double), from The Hon. Sec., Rugger Dance Committee, Guy's Hospital, S.E.1.

MEDICAL SCHOOL.

Applications are invited for the appointment of Casualty Surgeon, duties to commence as soon as possible, at a salary of £850 per annum. Applications to be submitted to the Dean of the Medical School not later than 27th October, 1947, from whom a copy of the draft Standing Orders may be obtained.

Applications are invited for the appointment of Registrar to the Pædiatric Department as from 1st November, 1947. Salary £500 per annum. The appointment is for two years in the first instance. Copies of Standing Orders and forms of application obtainable from the Dean's Office, to whom applications should be forwarded not later than 27th October, 1947.

Eds. {D.H.F. H.A.R.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

IT has come to our ears recently, that the *Gazette* has been the object not only of considerable criticism, but on one occasion at least, of a fair measure of abuse. This is your *Gazette*. This then is your matter. Criticism can be healthy and helpful. Some of the criticism heard at secondhand, was. Abuse is seldom either, and the abuse recently levelled was no exception. We ask you to give the matter your earnest attention. Do you or do you not get the type of journal you desire?

Not in any sense as a self-defence, but in order that any suggestions may be practicable, may we draw to your attention two facts. Firstly, there is a considerable shortage of paper. You can see that for yourselves. Your journal is a mere shadow of its former self. That is beyond the power of our correction, and we can only give you our assurance that we cover with print all the paper that we are allowed. Secondly, there is a considerable portion of each issue given over to advertising matter. Every journal must do this to make ends meet, and, in any one case, the proportion of paper allotted to such matter depends on the difference between the income from subscriptions and the cost of production. We need hardly mention that the latter has increased enormously since the war started, whereas the subscription rate has remained unaltered, and in the case of the Clubs' Union bulk subscription for its members, has actually decreased. On the present balance it is quite impossible to reduce the advertisements, and on account of these two facts, rationing and economy, therefore quite impossible to enlarge the volume of reading matter.

The point for your consideration then, is whether such space as you see occupied at present by Passim, the main and subsidiary article, correspondence, sport and Hospital information, is occupied as you would have it. It is not for us, the Editors, to print what we think fit, but to print what we think you think fit. And that has been and is our endeavour. Until recently we were led to believe we had met with a modicum of success. It is true that only about one-fifth of our readers attend the Hospital and have an opportunity thereby of rubbing shoulders with us and either abusing or commending us. Those people, therefore, have the Editorial ear, and the *Gazette* in all probability evolves along lines dictated by them. Seldom, if ever, do we receive criticism either constructive or destructive from the four-fifths of our readers in the outside world, those readers who would need to write to express their views. A murmuring and a muttering behind our backs and to people in no way associated with the management of the *Gazette* is not only foolish but futile into the bargain. Once more, this is your *Gazette*. Our object is to give you to read once a fortnight such matter as you want to read. His Majesty's postman delivers at our door, and there can be no excuse other than laziness for your not letting *us—us*—know what you want.

Perhaps the commonest form of criticism that has reached us secondhand of late, has been that there is insufficient local news of Guy's and of Guy's men past and present. We know a certain amount of what goes on at Guy's, and we report what we know and think of interest, but we cannot keep our ears glued permanently to the ground. We know a certain number of Guy's men (but by no means all) and cannot scavenge every piece of gossip. Of past Guy's men we know precious few, and little news. It has been suggested that once a month we print a column devoted to such matters. If that be your desire, then let it be done. But it can be done only if you, the readers, send us information to fill that column, information which you have and you think would interest other readers.

For the last time—*This is your Gazette.* It is up to you.

Normal and Defective Colour Vision

A Clinical Lecture delivered at Guy's Hospital by Mr. FRANK W. LAW, M.A., M.D., F.R.C.S., on May 29th, 1947.

GENTLEMEN,—It is possible that some apology is deemed necessary for my choice of subject. What justification, it may be asked, can there be for submitting for the consideration of undergraduate students, labouring under the burden of an overloaded curriculum, a complex and still largely theoretical subject which by its very nature compels approach from the physical, the physiological, and the psychological aspects? My answer would be twofold. Firstly, *ars causa artis* is accepted without question—indeed gratefully—and I can think of no valid reason why the same compliment should not be extended to science—another word for knowledge. Secondly, the future of medicine in this country would appear to be bound up with more extensive and stricter regulations and examinations in all walks of life, and this feature may be taken to include the examination of entrants for particular occupations from the point of view of fitness and suitability. Leaving on one side one's own views on the desirability of such wholesale "vetting," it seems clear that the examination of a man's or woman's colour vision would form part of many such examinations; this aspect provides my second justification.

A word as to nomenclature. I suppose it is too much to hope that the term "colour-blindness" will be eliminated from our scientific vocabulary, but it is a great pity that it ever came into common use, since it is not only a misnomer, but is also unscientific and actually misleading. It is admittedly not the only offender; "night blindness" is another, and it is as true to say that everybody is night blind as that nobody is. The person who has no colour discrimination whatever, and can match all colours with one radiation, is a great rarity, and may commonly be assumed to be suffering from some pathological condition, but he is the only one to whom the term colour-blind can strictly be applied. None the less the term as at present used includes all those who have any detectable defect whatever, even a slight shortening of one end of the spectrum, and I shall no doubt use the term in this sense in the course of my lecture. You will notice that in my title I did not make use of the term colour-blindness; defective colour vision is far preferable, and the old term can only be tolerated because long established custom has given it an accepted significance only amongst those whose

business it is to understand these things. Its condemnation in part derives from the meanings attached to it by laymen; so frequently it is assumed that a person dubbed colour-blind has no colour perception whatever.

THEORIES OF COLOUR VISION.

With the promise that I propose to cover the subject only very lightly it is essential that we should for a moment consider the main theories of colour vision in order that we may gain a position whence we may review, again as lightly, some of the theories which have been brought forward to explain defective colour vision. The difficulty of the subject is readily understood when one considers the necessarily subjective approach which is entailed; the problem of how the eye distinguishes colours—or, better, how the visual mechanism distinguishes one colour from another—is still unsolved, and I would hazard the guess that very much more must be known about the electrical and chemical processes which occur in the retina and brain before anything approaching a firm theory can be held. In the light of modern research some of the classical theories are coming to have little more than an historical value.

Von Kries' theory states that the mechanism of vision is essentially duplex; scotopic vision—*i.e.*, vision in diminished illumination with the dark-adapted eye—is achromatic and a function of the rods alone; photopic vision—*i.e.*, vision in bright illumination with the light-adapted eye—is a function of the cones alone, and involves the psychologically higher functions of form vision and colour vision. Von Kries proceeded further in his theory of the minutiæ of colour vision, but we will not consider this aspect further since the fundamental theory is not accepted by many; again, it is possible to superimpose other theories of colour vision on the foundation of the duplicity theory of vision.

The Trichromatic basis of colour mixture as determined by Newton—that (with certain exceptions) all hues can be compounded from three primary colours, red, green and blue—has naturally given rise to many Trichromatic theories of colour vision. Thomas Young postulated the presence of three types of cone which when stimulated by light produced a sensation of red, green and blue respectively, but not exclusively; Helmholtz, on the reasonable ground that the facts of visual acuity demanded a smaller visual unit than 3 cones, modified the theory (into what became known as the Young-Helmholtz theory) by postulating three different kinds of activity in any one cone. The analysis then took place in the retina, the re-synthesis in the brain; the resultant of all light stimuli can thus be completely represented as a function of three variables. Donder's theory accepts the fundamental basis of the Young-Helmholtz theory, and accepted four simple colour sensations on psychological grounds—red, green, yellow and blue—corresponding to four specific processes taking place as chemical dissociations in the brain.

McDougall's theory combines the three components theory with the duplicity theory, postulating a redistribution and elaboration of the impulses in the cerebral cortex. Roaf's theory postulates the presence of colour filters in front of the receptors, which he again considered to be in three sets.

Trichromatic theories are essentially physical in conception; even Leonardo da Vinci (1651) wrote of the psychological "colour square" in preference to the colour triangle, and the presence of four primary spectral colour sensations is readily acceptable. The opponent-colours theory of Hering may be

considered to be based on this postulate; though by adding white and black he assumed six primary sensations. His theory hypothecates three primary retinal substances which are broken down by red, yellow and white light respectively, and built up again by green, blue and black. The Ladd-Franklin theory attempts to combine the theories of Young-Helmholtz and Hering, and at the same time to reconcile them with the duplicity theory; it has an evolutionary basis, is very ingenious, and accounts satisfactorily for many of the observed facts of normal and abnormal colour vision.

Finally, many multichromatic theories have been put forward, more speculative in nature, into which you will by now be relieved to hear that we have not time to enter.

DEFECTIVE COLOUR VISION.

The characteristic of " colour-blind " persons is that the total number of distinct colours which they are able to recognise is significantly smaller than the number which the majority of observers—or to put it another way, which the normal observer—can recognise under similar conditions. We must note that " colour blindness " is a deficient and not a different form of vision; its extent cannot be measured by the total number of colours which can be recognised since the reduced discrimination is more evident in some ranges of colour than in others, so that this information would not be specific enough. Defective subjects become very ingenious in making up for their defect by relying upon brightness differences and other variations; in the absence of such variations the most striking deficiency is usually greater when they attempt to distinguish red from yellow or yellow from green.

From the historical standpoint it is of interest to note that the attention of scientists was first led to the analysis of the sensations of the colour defective subject by the observations of the chemist John Dalton (1798) upon his own case; so great was the stir produced that for long the defect was referred to as Daltonism. It is permissible in passing to express the hope that the name Dalton does not necessarily and always connote defective vision, whether polychromatic, political or economic.

In the next part of my lecture I shall quote freely from a recent Report on Defective Colour Vision in Industry, published by the Physical Society.

MISTAKES OF THE COLOUR-DEFECTIVE.

Our next concern is to consider how this reduced colour discrimination, which can lead to identity between colours which appear wholly different to the normal observer, will be expressed in the behaviour of the person with defective colour vision.

We have first, however, to note an extremely important fact. When, as children, we begin to recognise the differences between colours and we are taught their names, each colour is learnt through association with a particular object. We are taught that one brick is red, another green, a third blue, and so on. A banana, we are assured, is yellow, an orange is orange, the grass is green, the sky blue, until eventually we have a great many objects which help us by association to link up each colour sensation with its appropriate name. The colour-blind child will learn in the same way, and among the comparatively limited number of colours encountered in the nursery it may well be a rare occurrence for two distinct names to be given to what appear to him to be the

same colours. If this should happen it will be a source of great confusion to him, but in most cases his ability to detect brightness differences will enable him to make some distinction, and he will conclude that it is to this difference that the two names refer.

Because he has been taught that green is the colour which grass possesses, the colour-blind person, when asked the colour of grass, will naturally reverse the process and reply " Green," whatever the quality of his visual sensation. Furthermore, it happens that greens and yellows are generally lighter than browns and reds, and this fact may stand the colour-blind in good stead on many occasions in helping him to differentiate one from the other. It is a matter for genuine satisfaction that there are these subsidiary aids to assist the colour-blind person to describe the colour of an object correctly. He may, it is true, lose something of the beauties of nature through his reduced range of colours, but since he will be quite unaware of the nature of his loss it is unlikely to trouble him overmuch. The more embarrassing aspect of his defect is his liability under certain conditions to behave in an abnormal manner, but it is only when the incidental aids to correct colour perception are removed that the colour-blind person becomes liable to make noticeable and even glaring errors.

Let us suppose that we have a situation in which there is no external clue to the colour of an object. What type of mistake should we expect from the colour-blind ? If we are dealing with surface colours as distinct from coloured lights, we should find that he will have no difficulty in identifying white surfaces correctly, because such surfaces reflect a high percentage of the light incident on them. A yellow surface should also present no difficulty, since although it too reflects most of the incident light, absorption of the blue rays will serve to distinguish it from white. Confusion will arise, however, when darker yellow surfaces have to be distinguished from greens and oranges and reds of varying degrees of lightness and, indeed, among many of the darker and also of the less saturated colours. A sample may then be given the wrong name or two samples may be considered to match each other when, to the normal eye, they may look very different. Thus a colour-blind person who is asked to fetch an article of a certain colour as described to him by name may often produce the wrong article, or, if asked to sort out a number of articles by their colour alone may mix up the different groups.

The type and number of mistakes will, of course, depend on the type and degree of defect to which the colour-blind person is subject. But it will also depend on the conditions under which he is working. Persons with normal colour vision often have difficulty in recognising colours when the lighting is bad or the objects are dirty or small in size. Similarly the number of mistakes made by a colour-blind person increases under these more difficult conditions. Thus while the colour-blind may succeed in distinguishing between red and green signal lights when close at hand, yet when these are seen as pin-points of light in the distance, or through fog or rain, they will be far more liable to error.

BRIGHTNESS MATCHING AND COLOUR MATCHING.

We have emphasised the fact that the essential characteristic of colour-blindness is a reduced ability to differentiate colours. This naturally leads to errors in colour naming and in colour matching, and it is these errors which are of practical consequence in the behaviour of the colour-blind individual.

But there are two other characteristics of his vision to which some attention should be paid. The first concerns the relative brightness or intensity of different colours as seen by the colour-blind observer. The extent to which rays of light stimulate the eye depends partly on the energy and partly on the wave-length of the light entering the eye. For a normal eye, green and yellow rays are more effective for a given energy than red and blue rays, and the same is broadly true for the colour-blind. But if careful measurements are made of the relative energy required in different parts of the spectrum to produce a given sensation of light, it is found that for a certain percentage of colour-blind individuals a much greater amount of " red energy " is required than is the case for normal observers. Put in another way, for these colour-blind people, red and orange lights and red and orange surfaces look much darker than they appear to the normal or to the other types of colour-blind; so that the extreme red end of the spectrum may even be invisible.

The second characteristic to which we must refer is concerned with colour mixing and colour matching. It is found that a normal person can match a colour by a suitable mixture of three coloured lights, say red, green and blue. All three together will produce white, red and green make yellow, red and blue make purple, and so on. This fact is the basis, for example, of three-colour photography. But there are a certain percentage of colour-blind people who can do all their colour matching by mixing only two coloured lights, say a yellow and blue. Both red and green can be matched by yellow alone, while blue-green, white and purple can be matched by suitable mixtures of yellow and blue. For these people, a two-colour system of photography would provide a satisfying system of colour reproduction.

Further, for those colour-blind people who still require a mixture of three radiations to do their colour matching, it is found that the mixtures they need for a match are different from those required by a normal observer. These facts are made use of in one or two of the tests for colour blindness, but except in a few specialised occupations, the phenomena do not constitute any additional handicap to the colour-blind.

A very small number of cases occur where colour matching is reduced to brightness matching alone, that is to say, any colour can be matched merely by varying the intensity of a single beam of light whatever its colour. With such people, all objects are seen in monochrome, as in an ordinary photograph; but since their defect is usually accompanied by other pathological symptoms, they do not come within the scope of this lecture.

(To be concluded)

An Appreciation

Miss D. WHARTON.

MISS DORIS WHARTON started training at Guy's in 1915 and now after thirty-two years continuous service to the hospital is retiring. Known throughout Guy's as Sister Queen or more affectionately as " Queen," Miss Wharton held the post of sister of that ward from February, 1921, up to the beginning of the last war.

A woman of great character and determination, a born nurse; patients in Queen were literally not allowed to die. Miss Wharton had that gift of

imparting her knowledge to others and any nurse who was privileged to work under her was indeed fortunate. There was no greater honour amongst the nursing staff than " strings for Queen."

While being a little brusque with the patient who had little the matter, her sympathy, kindness and untiring efforts for the ill patient were inexhaustible.

During the war, Miss Wharton was Sister of Mary Ward at Farnborough, and lastly in charge of the Forces Military Orthopædic Ward, Orpington, of which position she made a great success.

An untiring and indefatigable worker, Miss Wharton has given of her best to the Hospital and I am sure everyone at Guy's will wish her many years of active retirement.

V.M.B.

Guy's Hospital Nurses' Prize Day

THURSDAY, October 2nd, was a memorable day for the nurses in training at Guy's. For the first time in the history of the school nurses received their prizes at a meeting to which their parents and friends were invited. In the past, the prizes had been presented at the annual meeting of the Guy's Hospital Past and Present Nurses' League. It was felt that a Nursing School of 550 students should have a day set apart for this ceremony. Tea was served in the Nuffield Nurses' Home at 4 p.m. to a large number of parents and friends and other visitors, including governors, members of the medical staff, Matrons of other training schools and many nursing celebrities. The Mistresses of some of the large girls' schools were also invited. The Physiology Theatre, lent by courtesy of the Dean was well filled. Lord Cunliffe, the Treasurer, was in the chair, and gave a short address of welcome. The Matron and Superintendent both spoke briefly, giving the audience interesting details of the training of the nurses at Guy's. The Sister Tutors presented their reports on the work of the past year. Lady Cunliffe, after accepting a bouquet of flowers from the nurses then presented the Butterworth Medal for 7 years consecutive service to Sisters F. Carter, Dalbiac, and Zerney (née MacNab). The prize winners of the year received their prizes. *Guy's Final Examination* 1st Prizes, Nurses J. Thomson, P. James, D. Avarne. 2nd Prizes, Nurses R. Hamilton, A. Hopkins, A. Rigby, E. Luckraft. *Medicine and Medical Nursing*, 1st Prizes, Nurses M. Lewis, T. Dartnall, J. Wastell. 2nd Prizes, Nurses C. Grove, M. Moore, B. Rix. *Surgery and Surgical Nursing*, 1st Prizes, Nurses B. Rix, M. Moore, M. Lowery, F. Smith. 2nd Prizes, Nurses M. MacIlwaine, H. V. Taylor, T. Swindells, V. M. Moss. *Gynæcology and Special Diseases*, 1st Prizes, Nurses E. Weir, T. Swindells, J. Wastell. 2nd Prize, Nurse T. Dartnall. *Pharmacology*, 1st Prizes, Nurses J. Cox, A. Belsham, M. Lowery, B. Woodward. 2nd Prizes, Nurses M. Dale, E. Weir, S. Barclay, M. Bass.

The last item on the programme was the address by Sir Herbert Lightfoot Eason, a very welcome and distinguished guest. Sir Herbert with his 52 years' connection with Guy's, and as a result of his detailed study of its history and traditions was able to give a picture of the evolution of the nurse's life and training from 1725. He quoted references from the House Committee records giving details of the wages, living conditions, and emoluments (lodging, coals, candles and Small beer) of the nurses (so called) and " watchers " employed in those days. The wages ranged from £8 per annum for the nurses to £50

for the Matron whose only emoluments were coal and Small beer. These glimpses of the dark past in the history of nursing led up to a graphic description of the "Nursing Row" in 1880, a bitter quarrel between the Matron, Miss Burt, and the medical staff, who objected to her transferring nurses from one ward to another. The staff expected to keep their own particular nurses in one ward for the whole of their nursing career. The bitterness of the quarrel made headlines in the newspapers. One disastrous sequel was the famous law suit, the trial at the Old Bailey of Pleasance Louisa Ingle, nurse, feloniously killing and slaying a patient, by putting her into a cold bath. Sir Herbert described this as a gross miscarriage of justice, as so far as the nursing staff knew the diagnosis was one of hysteria, though the patient was really suffering from Tuberculous meningitis. The Judge in summing up, deplored the disputes which had arisen "between those who ought to be working together amicably with one accord in order to alleviate the sufferings of the pained and poor and distressed," and mitigated the sentence to three months' imprisonment, without the degradation of hard labour. Sir Herbert presented the copy of the trial to the nurses' library. Finally addressing the nurses present, he repeated his conviction that an indelible impression is made on the patient by two people in the hospital, the porter in the Front Lodge and the nurse who receives the patient in the ward. The patient remembers more than anything else of his stay in hospital, the kindness of the nurses who cared for him.

The nursing staff thank Sir Herbert for his most interesting and inspiring address.

List of Entries

GUY'S HOSPITAL MEDICAL SCHOOL
OCTOBER, 1947

1st YEAR STUDENTS.

Name and School.

*Adamson, D. P., Kilburn Grammar School.
*Batcheldor, M. C., Cranbrook School.
*Bishop, C., Liverpool Institute High School.
*Boger, J. R. F., Marlborough College.
*Bowen, P. D., Swansea Grammar School.
*Boyd, W. M. S., R.N. College, Dartmouth.
*Bullard, J. A. A., Watford Grammar School.
*Burch, L. R., Scarborough College.
*Burke, D. V., Stationers' Company Secondary School.
Calne, R. Y., Lancing College.
Carrasco, T. Z., British East Africa.
*Collins, B. B., Ratcliffe College, Leicester.
*Cook, P., Priory Secondary School, Shrewsbury.
*Croft, J. L., Clayesmore School.
*Daw, G. H., Charterhouse.
*Dodshon, D., Alderman Wraith School, Spennymoor.
*Dominick, A. G. F., Ipswich School.
*Duke, J. R., Strathallan School, Perthshire.
*Farrell, R. H., Dartford Grammar School.
*Fraser, I. U., Caterham School.
*Fuller, I. C., Bedford School.
*Harris, D., Westminster City School.
*Haydon, A. C., Truro School.
*Hoskyns-Jones, J. H., Grove Park County School, Wrexham.
*Howarth, E. C., Hertford Grammar School.
*Jap, K. S., Malayan Seminary, Singapore.
*Jenkins, L. R., Cardiff High School.
*Jones, R. F. N., St. Olave's and St. Saviour's Grammar School.
*Jones, R. G., Ogmore Vale Secondary School.
*Kelly, K., Hitchin Grammar School.
*Lester, E. R., Bedford School.
*MacDiarmid, Agnes G., Glasgow High School.
*Martin, J. D., Aldenham School.
*Martin, P. A. T., Magdalen College School.
*Milton, R. J. S., Sutton County School.
*Moore, W. P. N., Downside School.
*Mullally, Sheila M., Asumption Convent, Ramsgate.
*Orr, R. G., Caterham School.
*Parson, J. V., Blundell's School.
*Peters, J. H., Salford Royal Technical College.
*Peters, K. E. G., Ardingly College.
*Phillips, M. R., Bedwellty Grammar School.
*Pryce, J. D., St. Edwards Orphanage, Liverpool.
*Rae, I. F. S., Malmesbury Secondary School.
*Rozario, J. A., St. Joseph's College, India.
Scott, S. C. C., King's College School, Wimbledon.
Smith, Patricia J., St. George's School, Ascot.
*Stephen, T. B., King Edward VII, Lytham, Lancs.
*Stewart, A. P. O., Canton High School, Cardiff.
Stones, Muriel J. M., Harrogate Grammar School.
*Strelling, M. K., Hymers College, Hull.
*Tudgay, B. A., Douai School.
Turk, J. L., Malvern College.
*Walker, K. P., Haberdashers' Aske's School, Hatcham.
Williams, Nora M., St. Anne's Convent, Birmingham.
*Yates, R. W. P., Tonbridge School.

2nd YEAR STUDENTS.

Name and School.

Booth, Ann, Boston High School.
*Burgess, F. d'U., Durban High School.
*Campion, Elizabeth, Tortington Park, Arundel.

*Carr, H. G., St. Albans School.
Cremin, B. J., Mount St. Mary's College.
Davies, W. F. T., Llandilo Grammar School.
*Dennis, J., Neath County School.
*Eastwood, J., Holme Valley Grammar School.
Elias, P. S., Vienna State College and Battersea Polytechnic.
Fram, A. I., Nottingham High School.
Fung-a-Fat, A. G. E., Queens College, Georgetown British Guiana.
Harris, D. C., Harrow Weald County School.
*Herz, E. R., Chigwell School.
*Heylen, Josephine C. M., Belgium and University Tutorial College.
Holden, P. N. A., Normanton Grammar School, Yorks.
*Jackson, B. G., Hilton College, Natal.
*Jenkins, K., Sutton Coldfield Grammar School.
Konfortion, P., Royal College of Mauritius.
Kumar, R., Aitchison College, India.
*Lay, C. E., St. Thomas's Central School, London.
*Montague, Joan M., Ladies' College, Guernsey.
*Morrison, Eleanor, Cheltenham Ladies' College.
Newton, Joan M., St. Bernard's Convent High School, Westcliff-on-Sea.
*Opie, C. H., Tettenhall College, Staffs.
*Pentney, Millicent J., Wychwood School, Oxford.
*Packer, P., Diocesan College, Cape Town.
*Pritchard, J. F., Epsom College.
*Ross, A., Bromley County School.
*Saldanha, Rita M., St. Augustines Priory, Ealing.
Shotts, A., St. Paul's School.
*Spencer, E. C., Haberdashers' Aske's School, Hatcham.
*Stebbing, P. R., Dulwich College.
St. John, W. A., Harrison College, Barbados.
*Strigner, A. E., St. Aloysius College, Highgate.
*Thornton, R. L. G., Bromsgrove School.
*Waye, Joyce D., Hitchin Girls' Grammar School.
Wiernik, I. Ruth, Priory School for Girls, Shrewsbury.

GUY'S HOSPITAL DENTAL SCHOOL

OCTOBER, 1947

PRE-MED. & FIRST B.D.S. STUDENTS.

Name and School.

*Allan, F., Vienna.
Allison, A., Ayr Academy.
*Artes, E. J., Elliott Secondary School.
*Anderson, J. D., David Stewart's College, Edinburgh.
Aufricht, Mary M., Harrogate Grammar School.
*Blake, D. E., Aldenham School, Herts.
*Bosson, E. F., St. Marylebone Grammar School.
*Brown, F. L., Tottenham County School.
Cahill, W. A. B., St. George's College, Weybridge.
*Castle, A. E., Hinckley Grammar School.
Chant, D. I., Gillingham Grammar School, Dorset.
*Coker, F. L., Grammar School, Llanelly, Carms.
*Cornhill, B. S. H., Torquay Grammar School.
*Davies, J. G., Cranleigh.
*Dawson, P. N., Lancing College.
*Edworthy, S. W., Cheam Central School.
*Fearn, A. d'A, Shrewsbury School.
Frew, K. M., Aldenham School.
*Gibson, A., Alderman Wraith Secondary School, Co. Durham.
*Gibson, R. J. A., Charterhouse.
*Grantley-Smith, A. B., St. Dunstan's College.
*Habberfield-Bateman, D. R., Bedford School.
*Halestrap, H. J., Whitgift School, Croydon.
*Hall, R. F., Queen's College, British Guiana.
*Hardy, R. E. W., Brentwood School.
Hewitt, S. L., St. Joseph's Academy, Blackheath.
*Hughes, M. G., Cowbridge Grammar School.
*Hunter, G. L., County Grammar School, Gravesend.
*Hutchinson, D. K., Liverpool College.
*Ingram, G. R. B., Bradfield College, Berks.
*Jeffery, R. C., Heath Clark School, Thornton Heath.
Jennings, Diana M. E., Ealing High School.
*Jones, A. F., Dauntsey's School.
Jones, M. F., Ratcliffe College, Leicester.
*MacLeod, D. H., St. Albans School.
*Meyer, H. C. F., Beaumont College, Old Windsor.
*Miller, B. U. E., Wintringham Secondary School.
Milne, Ann, Girl's County Grammar School, Penzance.
*Moore, C. W., Stoke Newington Central School, London.
*Pownall, R. H., Southgate County School.
*Prince, A. G., Churchers College, Petersfield.
*Reeves, N. H., Sir Walter St. John's School, S.W.11.
*Reynolds, E. P., Dulwich College.
Robinson, C. F. M., Gresham School, Holt.
*Scoones, J. M., Rutlish School.
*Sertin, P. F., Merchant Taylor's School.
*Sharp, R., South Shields High School.
Sharpe, J. W., Magdalen College School, Oxford.
Shotts, Nina, Haberdashers' Aske's School, Acton.
*Smith, T., Felixstowe County Secondary School.
*Tarrant, A. T., Harvey Grammar School, Folkestone.
*Thomas, I. L., Taunton School.
Thomas, Maureen S., Convent of the Sacred Heart, Whetstone.
*Thompson, E. T. P., Manor House School, Clapham.
*Timms, D. J., Monmouth School.
*Trist, F. H., Habberdasher's Aske's School, Hatcham.
*Turner, J. M., St. Lawrence College, Ramsgate.
*Watkins, G. A., Wintringham Secondary School, Grimsby.
*Williams, A. M., Friern Barnet Grammar School.
*Williams, J. T., Queen Elizabeth School, Crediton, Devon.
*Wylie, J. F., Chester College, Harrow.

1st YEAR L.D.S. AND 2nd YEAR B.D.S.

Name and School.

Allen, P. R., Wellingborough School, Northants.
Batty, R. L., Hemsworth Grammar School.
Bearn, E. M., Epsom College.
*Bond, A. E., Whitgift School, Croydon.
Burston, R. G. K., St. Joseph's College, Norwood.
*Clarke, R. M., Whitgift School, Croydon.
*Collinson, R. E., Dulwich College.
*Dexter, C. H., Caterham School.
Elias, P., Bootham School, York.
*Ellis, M., Highbury County School.
Fawcett, M. J., St. Bees, Cumberland.
Fooks, Angela R., Downe House School, Newbury.
Gill, Margaret F., Sutton Coldfield High School.
*Grigsby, D. C. L., Judd School, Tonbridge.
Harper, R. A., Battersea Grammar School.
*Harvey, H. R., Croydon High School.
*Hodson, R. F., County Grammar School, Oxted.
Holford, D. A., Highgate School.
*Jones, H., Neath Intermediate School.
*Kay, L. W., Leigh Municipal College.
Lee, R. E., Culford School.
*Lightburn, K. R. H., Ampleforth College.
McCormick, J. H., Epsom College.
*Malyon, N. E., Haberdasher's Aske's School, Hatcham.
Muscat, R. V. S., Isleworth County School.
O'Connell, M. H., St. Paul's School.
*Petty, J. C., Abingdon School.
Pickett, P. L., Bedford School.
*Poole, R. F., Gravesend Junior Technical School.
Rowe, R. D., Southend High School.
*Ryan, H. G. P., St. George's College, Weybridge.
Shindler, S., Greenford County School.
Stillwell, E. G. M., Enfield Grammar School.
*Sykes, P., King's School, Peterborough.
*Thomas, D. L. J., St. Edmond's School, Canterbury.
*Walker, C. J., Surbiton County School.
Warner, Dorothy E. M., South Hampstead High School.
*Wilkes, D. O., Deacon's School, Peterborough.
*Wilkie, W. J. P., Brentwood School.
*Wood, J. M., University College School.

CLINICAL PERIOD OF STUDY.

Name. and School.

*Bamford, J. A. C., Bishop's Stortford College and Emanuel College, Cambridge.
Bradbeer, J. W., Wycliffe College and St. John's College, Cambridge.
Butcher, A. S. F., City of London School and Queen's College, Cambridge.
Duke, B. O. L., Eastbourne College and Caius College, Cambridge.
Everson, J. F. A., Goudini High School, Rawsonville, Cape, and University of Cape Town.
Gorodi, P. H., Jones' West Monmouth School and Jesus College, Cambridge.
Gray, K. W., Ampleforth College, and Trinity College, Cambridge.
Hurst, J., High School, Newcastle-under-Lyme, and Selwyn College, Cambridge.
Muller, D. J., St. Paul's School and Oriel College, Oxford.
Murray, D. B., Oundle School and Pembroke College, Cambridge.
Penney, G. N. St.J., Perse School and Queen's College, Cambridge.
Pugh, D. R., Rugby School and Trinity Hall, Cambridge.
Rees, J. R., Swansea Grammar School and Trinity College, Cambridge.
Rhys-Jones, W. G., Lancing College and St. John's College, Oxford.
Smith, J. A. J., Wimbleson College and Trinity College, Cambridge.
Williams, P. L., West Monmouthshire School, Pontypool, and St. Catharine's College, Camb.

** Ex-Service or Work of National Importance.*

Sport

GUY'S HOSPITAL RUGBY FOOTBALL CLUB.

FIXTURES 1947–8.

Date 1947	1st XV. *Ground.*	*Opponents.*	"A" XV. *Ground.*	*Opponents.*
Sept. 20	H.O.P.	Catford Bridge	H.O.P.	Catford Bridge "A"
,, 27	H.O.P.	Blackheath	Blackheath	Blackheath "A"
Oct. 4	Portsmouth	United Services	H.O.P.	United Services "A"
,, 11	Aberavon	Aberavon	Westcliff	Old Westcliffians
,, 18	H.O.P.	Bedford	Bedford	Bedford Wanderers
,, 25	Plymouth	Plymouth Albion	H.O.P.	Trials
Nov. 1	H.O.P.	Old Blues	Fairlop	Old Blues "A"
,, 5			H.O.P.	Camb. Univ. LX
,, 8	Birkenhead	Birkenhead Park	H.O.P.	Hendon
,, 12	H.O.P.	Cambridge Univ.		
,, 15	Old Deer Park	Rosslyn Park	H.O.P.	Rossiyn Park "A"
,, 17	H.O.P.	Univ. College, Dublin		
,, 22	H.O.P.	Metropolitan Police	H.O.P.	Gravesend
,, 29	H.O.P.	Coventry	Teddington	Harlequins "A"
Dec. 6	H.O.P.	Swansea	Richmond	London Scottish "A"
,, 13	Thames Ditton	Old Cranleighians	H.O.P.	Old Cranleighians "A"
,, 20	Moseley	Moseley	H.O.P.	Tonbridge
,, 27	H.O.P.	Old Millhillians		
1948				
Jan. 3	H.O.P.	Old Merchant Taylors	Croxley Green	Old Merchant Taylors "A"
,, 7	H.O.P.	Royal Air Force		
,, 10	H.O.P.	Wasps	Sudbury	Wasps "A"
,, 17	Dulwich	Old Alleynians	Twickenham	England *v.* Wales
	Twickenham	England *v.* Wales		
,, 24	S. Croydon	Old Whitgiftians	H.O.P.	Harlequins "A"
,, 31	H.O.P.	Devonport Services	Rochester	Rochester
Feb. 7	Coventry	Coventry	H.O.P.	Brighton
,, 14	H.O.P.	London Irish	H.O.P.	London Irish "A"
	Twickenham	England *v.* Ireland	Twickenham	England *v.* Ireland
,, 21	H.O.P.	Aberavon	H.O.P.	Magdalen Coll., Oxford
,, 28	Herne Hill	London Welsh	H.O.P.	R.A.M.C.
Mar. 6	H.O.P.	Nuneaton	Well Hall	Woolwich Polytechnic
,, 13	Thames Ditton	Old Paulines	H.O.P.	Old Paulines "A"
,, 20	H.O.P.	Gloucester	Herne Hill	London Welsh "A"
Easter 27	Penzance	Penzance and Newlyn		
Easter 29	Falmouth	Falmouth		
Easter 30	Exeter	Exeter		
Apr. 3	H.O.P.	Richmond		

RUGBY FOOTBALL

GUY'S *v.* CATFORD BRIDGE.

(*Played at H.O.P., Saturday, Sept. 20th.*)

Result : Guy's 24 pts., Catford Bridge 3.

The opening match of the season against Catford Bridge resulted in victory for the hospital by 3 goals, 1 penalty goal, and 2 tries to a try.

Outstanding performer was undoubtedly H. Brunow the new captain, at stand-off half, whose safe handling of the ball, careful nursing of his backs, and long accurate left foot touch-kicking introduced a high class of football much welcomed in a Guy's team. A. B. Lee returned to the pack following service in the Royal Navy and F. Retief, from Cape Town University, was given a chance at centre-threequarter, and played well enough to indicate distinct promise with more experience.

There was much to admire in the general play of the team but it would be wrong to say that the team worked smoothly. There were many faults, especially by the forwards, but one feels certain these can be remedied by careful coaching.

Guy's took the lead within two minutes of the start when F. Le Clus took a return pass from his brother and crossed for an unconverted try, which was followed by a nice movement between H. Brunow and F. Le Clus which sent in D. Le Clus to touch down by the posts for T. L. T. Lewis to convert. F. Retief following up well after H. Brunow had kicked ahead took advantage of a mistake by the Catford Bridge full-back and added an opportunist try and with a penalty goal by T. L. T. Lewis, the hospital led by 16 points to nil at half-time.

Following the interval, Guy's found it extremely difficult to penetrate the Catford Bridge defence and this led to many errors in the execution of promising movements. D. Le Clus who had been injured when scoring his try was compelled to go off at half-time and M. Hatton went on the wing to make full use of the opportunities that came his way by crossing for two very good tries one of which T. L. T. Lewis converted from in front of the posts.

Guy's Team : T. L. T. Lewis, D. N. H. Owen, F. Retief, F. Le Clus, D. Le Clus, H. Brunow (Captain), P. D. V. Harrett, A. B. Lee, J. Keeling, W. Wolfsohn, B. W. Cole, A. G. Parks, A. C. de B. Eksteen, M. Hatton, A. J. de Villiers.

GUY'S *v.* BLACKHEATH

(*Played at H.O.P. on Saturday, 27th September.*)

Result : Guy's 3, Blackheath 7.

The Hospital showed excellent form against Blackheath and were somewhat unfortunate in losing by the small margin of a dropped goal and a try to a try.

Blackheath had a strong side which included four South Africans of whom M. J. Davies and R. E. Luyt were recognised as the war-time Oxford University blues. Other prominent players in their side were S. T. J. Walter, Gloucestershire, W. O. Chadwick, England, and 'Varsity players in D. G. England and P. B. C. Moore. Nevertheless, Guy's set about their task with complete confidence, and thanks to a brilliant display by the forwards kept Blackheath frequently on the defensive and had our backs been up to the same standard as the pack points would surely have accumulated.

H. Brunow, who played in spite of an injury received at practice, and P. D. V. Harrett, had an interesting duel against M. J. Davies and J. L. Chambers which was won by the Guy's pair of half-backs who had more of the ball from the scrums owing to J. Keeling's superior hooking against W. O. Chadwick. Our three-quarters, although not impressive in attack, did a lot of good work in defence, and they, combined with the excellent tackling and covering up by the forwards, held the dangerous Blackheath backs well in check.

In the early stages, H. Brunow completely baffled the opposition and drawing the whole of the defence had the mortification of seeing his final pass dropped. T. L. T. Lewis had a chance from a penalty kick from a reasonably good position but failed, and then against the run of play, R. E. Luyt dropped a good goal for Blackheath. H. Brunow was constantly sending his backs away but faulty passing halted their movements against a stone-wall defence.

The second half opened with a grand dribble by M. Hatton, and J. Keeling had his kick charged down following a " mark." Blackheath improved greatly and from a breakaway from a loose scrum carried play to the corner where A. C. Burcher crossed for an unconverted try. T. L. T. Lewis was frequently called upon to repel determined rushes and did his work admirably. A. de Villiers looked as if he had touched down for a good try but the referee decided otherwise, and then followed a period of heavy pressure. H. Brunow just failed with a drop at goal, but Guy's forwards made an onslaught to

the Blackheath line which resulted in M. Hatton touching down for a try.

On their display in this game, Guy's looked really good and time will tell whether the hospital have, what many sound judges consider, their best team for some years.

Team : T. L. T. Lewis, D. N. H. Owen, F. Retief, F. Le Clus, K. R. Heber, H. Brunow (Captain), P. D. V. Harrett, A. Du Plessis, J. Kelling, A. B. Lee, A. G. Parks, B. W. Cole, B. Eksteen, M. Hatton, A. De Villiers.

Hospital Information, etc.

NOTICES

DEPARTMENT OF SURGERY.

On Saturday, November 1st, there will be a Clinico-Pathological Meeting in the Anatomy Theatre at 10.30 a.m.

On Tuesday, November 4th, there will be a further demonstration in the series "Operative Procedures" in Theatre III at mid-day.

On Saturday, November 8th, Professor Paterson Ross, of St. Bartholomew's Hospital, will be conducting a Departmental Round at 10 a.m.

During the first half of November there will be an exhibition in the Gordon Museum, illustrative of "The Surgery of Neuro-Muscular Incoordination."

DEPARTMENTS OF MORBID ANATOMY AND MEDICINE.

A combined Clinico-Pathological meeting will be held in the Pathological Lecture Theatre on Friday, 31st October, 1947, at 2.15 p.m., when the following cases will be shown :—

1. A case of Generalised Military Tuberculosis.
2. A case of Pulmonary Tuberculosis and Tuberculous Meningitis.
3. A case of Idiopathic Steatorrhœa, Macrocytic Anæmia and Tetany.

GUY'S HOSPITAL DENTAL SCHOOL.

The following Postgraduate courses will be held during the Winter Term, 1947 :—

(1) Dental Prosthetics commencing 10th November.
(2) Advanced Operative Technique commencing 24th November.
(3) Orthodontics and Children's Dentistry commencing 8th December.

Each of the above-mentioned courses will be of two weeks' duration and the fee will be twenty guineas per course. Further particulars can be obtained from the Dean.

DENTAL SOCIETY.

The next meeting of the Dental Society will be held on Thursday, October 30th, at 5 p.m., in the Dental Theatre, Old Pathological Block (preceded by tea in the College at 4.30 p.m.), when Mr. J. W. McLean will read a paper on "Some Developmental Aspects of Acrylic Resins," and Mr. A. Shotts, L.D.S.Eng., will read a casual communication on "The Child's Attitude to the Dental General Anæsthetic."..

A. H. R. ROWE,
Hon. Secretary.

DENTAL DANCE.

The Annual Dental Dance will be held at Grosvenor House, Park Lane, W.1, on Friday, November 21st, from 8 p.m. to 1 a.m. Dancing will be to the music of Sidney Lipton and his Orchestra, and there will be full bar facilities.

Tickets (price One Guinea, inclusive of Buffet) may be obtained from the Dance Secretaries. Applications should be made as early as possible, as numbers will be strictly limited.

I. A. NELSON, A. H. R. ROWE } *Hon. Dance Secretaries.*

CHANGES OF ADDRESS

Miss E. M. Harrison (late Sister in Charge Wilks Ward), Sunmachs, Haslingfield, Cambridge.

James C. Houston, M.D., 2, St. James Close, Frien Barnet Lane, N.20. (Tel. : Hillside 3949.)

T. B. Layton, D.S.O., M.S., F.R.C.S., Private : The Shaws, Newchapel Road, Lingfield, Surrey. Professional (Thurs. mornings) : 55, Wimpole Street, W.1. Appointments by telephone, WELbeck 2074. (Mon. to Fri. : 10.0 a.m. to 6.0 p.m.)

R. F. Pusey, B.D.S., M.R.C.S., 51, Calthorpe Road, Edgbaston, Birmingham, 15. (Tel. : Edgb. 2525–6.)

J. B. Robinson, M.D., M.R.C.P., at Ruthin Castle, N. Wales.

R. Vaughan Payne, M.Clin., F.R.C.S., Woodhay House, 17, Osborne Road, Windsor, Berks. (Tel. : Windsor 1121.)

J. H. Wildman, M.R.C.S., D.P.H., Asst. County M.O., Barnstaple, Devon ; c/o Bowden Farm, Ilfracombe, North Devon. (Tel. : Ilfracombe 238)

PAPERS BY GUY'S MEN

Andy, J. R. Scrub typhus Investigations in South-East Asia (3 Parts). War Office Report. *Army Medical Directorate*, March, 1947.

Ogilvie, Sir Heneage. The Hamilton Russell Memorial Lecture : The place of Surgery in the treatment of peptic ulcer. *Australian and New Zealand J. Surg.*, 1947, **17**, 3.

MARRIAGES

BULSTRODE—KENT.—On September 4th, 1947, J. C. Bulstrode, M.R.C.S., L.R.C.P., to Jacqueline Kent, B.Sc.

BIRTHS

COLE.—On October 11th, 1947, at 83 (Br.), General Hospital, Trieste, to Kathleen, wife of Major P. L. G. Cole, R.A.M.C.—a daughter (Jane Ingrid Pierson).

FIGGIS.—On October 16th, 1947, at The Firs, Harrow, to Jean (née Hargreaves), wife of Dr. M. M. Figgis—a daughter (Felicity Ann).

LAWS.—On September 23rd, 1947, at Farnborough, Kent, to Sheila (née Squire), wife of Dr. J. O. Laws, of Sevenoaks—a daughter (Jocelyn), sister to Judy Margaret.

LOMAX.—On October 9th, 1947, at the Provincial Hospital, to Margaret (née Evans), wife of Ronald Guy Lomax, of "Suttonbank," Young Road, Mill Park, Port Elizabeth, South Africa—a son (Ronald John).

UNSTEAD.—On August 27th, 1947, at Parklands Nursing Home, Durban, South Africa, to Nancy (née Bradford), wife of H. Ronald Unstead, L.D.S., R.C.S.—a daughter (Valerie Irene).

WILLIAMSON.—On August 20th, 1947, at Tenterden Nursing Home, Amersham, to Margaret (née Morrison, S.R.N.), wife of John R. Williamson—a son (Peter John).

DEATHS

BEADNELL.—On 27th September, 1947, at Petersfield, Charles M. Beadnell, C.B., K.H.P. (retired Surgeon Rear-Admiral).

MOORE.—On 10th September, 1947, at Worthing, James York Moore, O.B.E., M.R.C.S., L.R.C.P., Hythe Road, Worthing, Sussex.

Eds. { D.H.F. H.A.R.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

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PASSIM

THE course of instruction that a young man must undergo before he may be pronounced to the world as a doctor is long and varied. To the young enthusiastic schoolboy about to plunge into the exciting swim of university life, the commencement of his medical studies are, quite rightly, looked upon as the beginning of a great adventure. He dreams of the dramatic day when people will marvel at his brilliant diagnoses of obscure maladies, or when his skilful, long, thin fingers (surgeons' fingers must always be long and thin) play delicately with a scalpel as he swiftly removes some monstrous tumour from somewhere in the darkest regions behind the heart. The young tyro's fond relatives immediately picture him dissecting the human frame and it is only a matter of weeks before they expect him to cure all their aches and pains.

Little do his admirers know with what studies the beginner must first battle. No romantic procedure even remotely connected with the life of a doctor claims his working hours and he is still as far off dissecting a human body as his mother, assuming she is not a pathologist.

No, the poor, disillusioned youth must play with weights and wires and inclined planes; he must try and get excited about the antics of a Tangent Galvanometer, or the maniacal outbursts of that most dangerous of useful inventions, the Wimshurst machine. He has to pour a lot of evil-smelling things from one test-tube into another and watch them change colour or, alternatively, the bottom of the tube fall out. He learns what goes up the Phloem and down the Xylem and, what is more, he is expected to believe it! If he dares to ask a Wise Man the reason for these peculiar and shaming pastimes, he receives that all-powerful statement, made with one eye half-closed and a cynical knowing look, "Ah, you don't understand, it gives you a *grounding*." There the matter is ended and the wretched student must return to his specific gravity bottle and prove something that everyone is quite prepared to accept without personal investigation. He doesn't understand and he can't imagine what sort of grounding he is getting. He has certainly never heard of doctors, even famous ones, discussing the merits of the Weston Differential Pulley, and he is sure that the mention of a Bramah Press would provoke not even a raising of the eyebrows in the Athenæum.

However he plods along and, if he retains his reason, passes his first examination. The second year is better but still contains plenty of mumbo-jumbo in the way of Organic Chemistry. He learns to do the oddest tricks with a Benzene ring and the conversion of Glucose into Fructose is an escapade which, if he is frank, leaves him cold and very little the wiser.

The second examination out of the way, he buys a stethoscope and at last scents that atmosphere which he hopes will help to make him into a doctor.

He has waited two and a half years for this first breath and he finds life good. However, in spite of the comparative sanity of these years, he has to face Public Health, parts of which are important and parts of which seem included solely in case he should change his mind and become a sewer cleaner. He learns that a Long Hopper is not an insect and why a Hinckes-Bird ventilator is or is not any good in a blacked-out cowshed.

It is true that together with all these absurdities he studies and learns subjects that hold his interest and stimulate his progress towards his ambition, but unfortunately these more pleasant and valuable pursuits are incomprehensibly bound up with a mass of tiring and useless data. He finds his time overfilled with donkey-work which he knows must be done merely to satisfy an examiner and which he may quite safely forget after the inquisition is over.

Surely, with all these new brooms sweeping the country to-day, it is time that the medical syllabus was spring-cleaned. On no account let a medical training become an abbreviated correspondence course, but there is enough to be learnt without including items in the misguided belief that they serve some subtle yet essential use in the building of a medical man. They are dry rot and should be destroyed.

WE wish to thank the many readers who have written to us since the last issue of the *Gazette*. Their criticisms and compliments are very welcome and we appreciate their interest in their journal.

ON November 7th, Sir William Hale-White, our hospital's senior consulting physician, celebrated his ninetieth birthday. On behalf of our readers we extend to him our best wishes.

A limited number of Christmas Cards are ready for sale and may be obtained in the *Gazette* Office—price 6*s*. 6*d*. and 4*s*. 6*d*. per dozen including envelopes (postage 6*d*. extra). To avoid disappointment early purchase is advised.

An Appreciation

SISTER HARRISON.

THE retirement of Miss E. M. Harrison is sad news to those of us who have had the good fortune to work with her. A ward sister to whom nursing was a vocation and inefficiency a contemptible vice, can be ill-spared from Guy's. Her loss will be felt for many years to come.

"Our Daisy" as Miss Harrison was affectionately, if irreverently, termed (to her face only if you had known her for ten years) was one of the most striking characters that Guy's has cherished in the last quarter-of-a-century. Several generations of H.P's. have met her in her most formidable mood, have trembled at her gaze, yet have stayed to hold her so highly in their esteem as to admit to being permanently indebted for what she has taught them. The slacker, male or female, had short shift from her, for she was never one to suffer fools or shirkers gladly. To those who put their back into work, and who thought of the patient's welfare before all else, Miss Harrison would give unstinted help and loyalty.

She has never been known to spare herself. Even when ill she would drive her body to its work, spurn off-duty times, and even holidays, to care for a seriously sick patient. In the war she worked literally day and night, at first with casualties and later in the medical wards. Every air raid warning found her walking her ward giving encouragement to her patients who came to regard her as a mascot. Already at this time she was suffering from the illness which culminated this year in a desperate fight

for life. Strangely enough she was as good a patient as she was a nurse, and because of her determination and grit she survived.

Fortunately her health is returning and she can look forward to many years of happiness in retirement. The difficulty will be to protect her from demands on her professional services. Any Guy's man who has seen her at work will cry out for her aid should he, himself, be ill.

A woman of pluck, efficiency, integrity, iron determination, and deep kindness Guy's will be the worse without her.

A.H.D.

Normal and Defective Colour Vision

A Clinical Lecture delivered at Guy's Hospital by Mr. FRANK W. LAW, M.A., M.D., F.R.C.S., on May 29th, 1947.

(*concluded*)

CLASSIFICATION OF COLOUR-DEFECTIVES.

We must now consider how we can classify colour defective subjects in the light of the facts concerning their defect which we have already discussed. A simple form is the following :—

1. *Monochromats.* These have no colour discrimination ; the condition is rare and, as I have said, associated with pathological conditions of the visual apparatus.

2. *Dichromats.* These have a reduced colour discrimination, and can match any colour with a mixture of two radiations.

3. *Anomalous Trichromats.* These require three radiations for colour matching, but have reduced colour discrimination and make abnormal matches.

Further subdivision of Groups 2 and 3—the Dichromats and Anomalous Trichromats—is essential.

2. These are divided into—

(*a*) *Protanopes*, whose chief defect resides in the red and yellow regions where their brightness perception is much diminished, and who can match all colours by a mixture of blue and yellow.

(*b*) *Deuteranopes*, who can make similar matches to the Protanopes, but whose estimates of relative brightness does not noticeably differ from the normal.

(*c*) *Tritanopes*, who can match all colours by mixtures of red and green ; few in number.

Since Protanopes and Deuteranopes have their poorest hue discrimination in the red to green region of the spectrum, they are often classed together as " red-green blind " ; Tritanopes are worst in the blue to green region and are sometimes termed " blue-yellow blind."

Group 3 comprising the Trichromatic Anomalies can be similarly subdivided thus :—

(*a*) *Protanomalous*, who have a weakened perception of stimuli from the red end of the spectrum. They need more red than normal to mix with green to make yellow ; their match is therefore orange, or even red, to the normal observer.

(*b*) *Deuteranomalous*, who by contrast with the preceding group require an abnormal quantity of green to make the match, which may thus appear green to the normal.

(*c*) *Tritanomalous*, a largely theoretical group about which detailed information is lacking.

TRANSMISSION OF THE DEFECT.

In the great majority of cases, colour-blindness is congenital, but some loss of colour sense can be acquired, *e.g.*, by excessive smoking, or in certain toxic conditions. When a father is congenitally colour-blind his daughters will be carriers of the defect without themselves being defective, but none of his sons will be either colour-blind or carriers. When a mother is a carrier, half her sons will, on the average, be colour-blind and half her daughters will be carriers. The defect will, however, become evident in half the daughters of a carrier mother and a defective father; when both parents are colour-blind all daughters will be affected. It follows that the number of women who are colour-blind is very much smaller than the number of men. Statistics show that the percentage of colour-blind persons in the male population is approximately as follows :—

Anomalous trichromats	6.0 per cent.
Dichromats	2.0 per cent.
Total	8.0 per cent.

Information about the age at which defective colour vision becomes evident is conflicting. It seems certain that those who possess the defect do so from their earliest years, yet at the same time it has to be recognised that children may fail to describe colours correctly because they are mentally backward or through lack of education, and not through any defect in their visual apparatus. It is probably safe to say that where the education of a child has been reasonably good and where he has shown no signs of being backward, then if tests indicate that he is colour-blind at the age of 13 years or over, it can be assumed that his colour vision is defective.

THEORIES OF THE DEFECT.

One must confess that, in view of the multiplicity of theories of colour vision which we have noted even in our most superficial review, there is no possibility of giving you a neat watertight explanation of the cause or causes of defective colour vision; nor will there be until one has a theory of colour vision which fits all the observed facts, and explains all the observed anomalies, when it would cease to be a theory and take its place with the facts. The observed features of the various forms of defective colour vision are explained *in toto* by no single theory of colour vision, some fitting better into one theory and some into another; and it is a useful mental exercise to try and make out different varieties of colour vision defect on the basis of different theories of colour vision. This, then, I will leave to you for your diversion and proceed to describe some of the tests used in the investigation of defective colour vision.

TESTS FOR COLOUR VISION.

In that it is impossible for any person to form an accurate conception of the sensations of another, the devising of a wholly satisfactory test for colour-

blindness is a matter of extreme difficulty. Hence you may rightly assume that their number is legion and that no single test is completely satisfactory.

1. The first test that will occur to you consists in the use of the spectroscope. There is practically no limit to the extent of the investigations which may be made by this means, other than those imposed by time and the apparatus itself. The subject may be presented with a portion of one spectrum and asked to match it in a second. This method forms the basis of the Anomaloscope, the two fields having to be matched both for hue and intensity. The best-known test on these lines was designed by Nagel; other instruments on the same lines are the Eastman Colour Temperature Meter, the Visual Colorimeter, the Helmholtz Colour Mixer, the Abney Colourpatch Apparatus, and so on for a large series. An interesting instrument, as yet existing only as a prototype, comes from the Kodak Research Laboratories, and contains 11 pairs of colours placed side by side. The upper halves of each pair are filtered so that No. 1 is distinctly red and No. 9 distinctly green; the lower halves consist of yellow filters matching the upper in brightness for the normal trichromat. The kind of anomaly can be determined by the number of the pairs which the defective observer considers a good match both for hue and brightness.

2. One of the more practical tests is that provided by the use of Pseudo-Isochromatic Charts—so-called by those who like to lose themselves in a tangle of ebullient verbiage; but for us the term Confusion Charts will be adequate. These tests are composed of a series of cards on which are printed backgrounds of coloured spots, the sizes of which are carefully chosen, and interspersed among these background spots are figures, letters, or other shapes, also made of coloured spots of suitable size. The so-called confusion colours of the colour-blind are used, *i.e.*, green, yellow, orange, red, brown, pink, etc., usually of low saturation, and the brightness of these colours are adjusted so that the colour defective cannot make use of brightness discrimination. The appearance of the cards to the colour defective is such that the hue and brightness of the background and numeral (letter or shape) are very similar and he cannot readily differentiate between them. The quality of the light in which these tests are used is important; the illumination recommended, usually daylight, should be strictly adhered to. There are 8 or 9 of such tests but probably the best known is the Ishihara Test which I show you here. The demonstration of a defect by these charts is relatively simple, but it is difficult or impossible to assess the degree of the defect.

3. *Lantern Tests.* When it is considered how often it is necessary to differentiate coloured lights and signals—in such occupations as those of motor drivers, railway employees, sailors, airmen, etc.—the practical value of a lantern test is readily appreciated. Such tests are essentially simple, and need no explanation; they do, however, involve naming a colour, and this introduces a complication and may constitute a defect. There are many models of lantern in use, of which I show you one. Two sizes of aperture are available, and a wheel of coloured filters passes before the light, modified if necessary by frosted glasses to represent fog, rain, and so forth. There is some ground for believing that more accurate results may be obtained by using a double or even a triple aperture, and presenting different hues at each.

4. *Woolmatching Tests.* These tests were probably the first to be used for the detection of colour-blindness. The candidate is required to match various skeins of coloured wool, this being chosen as a good diffusing medium,

reflecting light equally in all directions. Although these tests have been widely used in the past, they are now considered to be inferior to other types of tests, and usually little value can be placed on the results obtained, though for a full practical assessment of colour defect they are most useful if employed as a supplementary test to a lantern examination.

The *Holmgren Wool Test* is one of the oldest and probably the best known of all colour-blindness tests ; it was introduced over 65 years ago after a serious railway disaster in Sweden which emphasised the need for testing the colour vision of certain classes of railway employees. It may be regarded as the prototype of all wool tests, the others being simple variants. In its usual form the test consists of three specimen skeins, bright green, purple and red, and the candidate has to choose, from about 125 skeins of wool of various hues and brightnesses, one skein, and one only, which he considered to be the nearest match for both hue and brightness for each of the three test colours. Further detail of examination may be made by asking the candidate to select all the skeins he can find which he would place in the same colour category as the test skein. The mistakes made by the red-green defectives are most interesting. I show you a set based on Holmgren's, as modified by Abney.

5. Finally, as to tests, it would not be difficult to name some 25 miscellaneous tests, dependent upon contrast or matching, which are in more or less common use. Some are merely copies of former ones, many have their own features of value, but it must always be remembered that no one test, other than a very expensive and elaborate colorimetric one, is capable of detecting and assessing defective colour vision with absolute certainty, but that this certainty may be more nearly approached if more than one type of test us used.

. . . . .

Such then, gentlemen, is a very superficial presentation of some aspects of a complicated and absorbing subject. I have not concealed its difficulties from you ; but I hope I have presented it in a manner which will make its approachability appeal and its interest stimulate ; if I have, I shall have served my purpose in helping you to apply the practical tests for the investigation of colour vision, a task which I feel sure will fall to the lot of many of you in the future.

Correspondence

"The Doctor of the Near Future"

SIR,—I have read the article entitled "The Doctor of the Near Future." There is ample room for improvement in the teaching and practise of medicine, but in my experience the criticisms levelled by P.F.S.S. are largely unjustified.

In speaking of medical education it has become a cliché that the old methods of teaching are out-moded and that the consultant staffs and registrars of Teaching Hospitals give a "lop-sided view of medicine to students." Your contributor goes on to amplify this with a series of mis-statements—"the spectular and complicated treatments and operations," the consultant "implanting . . . more than a tinge of disdain for the Family Doctor," when dealing with "illness . . . almost always when it is established firmly."

The treatment I was taught at Guy's was essentially simple and straightforward, based on the principle of the adequate dose of the appropriate drug, with reasonable dietetic manipulation and physiotherapy when required. Operations are, of course, sometimes spectacular and often complicated, but this is not the fault of the Surgeon,

furthermore every general practitioner should have seen such operations, should understand the risks entailed and know the chances of complete cure, amelioration or death. It is he who will often have to advise the patient and his family when such an operation is mooted.

No good Consultant is disdainful of the good Family Doctor—he knows too well his difficulties and his skill. Criticise he must when it is clear that the case with a palpable tumour has been treated symptomatically without examination, or that no examining finger has explored the rectum of the patient with six months history of diarrhœa and a large carcinoma of this region. One of Guy's most distinguished teachers was in general practice himself and the sons and fathers of others are or have been. Such men do not under-rate general practitioners. That the case of illness seen by the Consultant "is established firmly" when he sees it will be strenuously denied by all who teach at Out-Patients in these days when every girl with a cough of more than a week's duration is referred as a possible case of pulmonary tuberculosis, when organic disease must be excluded in every youth who faints and every housewife who has lost a few pounds in weight. The Consultant has no shortage of patients upon whom to teach the early diagnosis of disease, and to apply that "masterly inactivity" that Joey Hughes so wisely recommended while waiting for the signs to develop or the symptoms to disappear. Moreover, even when the disease is firmly established the diagnosis often remains elusive.

Now let us examine the statement about focussing the attention upon rare diseases. What fantastic nonsense this is. As I think back the pictures that come to my mind are of Frankie Steward examining a case of suspected appendicitis; Parsons discussing the septic hand; Slesinger teaching on Colles' fracture; Herbert French on cardiac murmurs and nephritis; Hurst on asthma and colitis; Ryle on dyspepsias, organic and functional; Geoffrey Marshall on bronchitis and tuberculosis; Cameron on infant feeding and the nervous child. All these are relatively common and exceedingly important. Even commoner conditions were encountered—tonsillitis, quinsy, pyelitis, acne, boils—I was taught on all of these. Was I, you may ask, taught on the subject of the common cold? The answer, Sir, is that no doctor will ever submit to the proper treatment of this condition and therefore he never teaches it. Rare diseases were, of course, seen and were rightly regarded as providing leaven of special interest to lighten the dough of everyday disease. It was from a case of multiple fibrocystic disease, however, that I learnt the basic facts of calcium metabolism, and a case of pellagra that drew my attention to the vitamin B complex—these cases are not a waste of time and much knowledge of more common disease is imparted during the study of rare conditions.

What then is omitted that makes the teaching lopsided? Is it Social Medicine, which is only the new study of one facet of the old disease? When I was a student Social Medicine was seldom stressed, partly because the machinery for modifying social conditions in individual cases was then less efficient than it is to-day. I should be surprised, however, if it is not now given the attention it deserves at Ryle's Hospital when its study is already recognised in other schools. The London Hospital is perhaps outstanding in this respect, but everywhere a minor revolution is being enacted in the re-orientation of teaching to include this aspect of disease. The effect of a man's work on his ulcer, the difficulties of the mother with mitral stenosis and a young family, the means of preventing the old man with senile tuberculosis from spreading the infection among his grandchildren, the rehabilitation of the rheumatoid arthritic, the rehousing of the family whose child has rheumatic fever—these subjects are commonly discussed after with the almoner and physiotherapist at the bedside and in the out-patient department.

Space is limited, Sir, or I should have liked to have defended the cardiologist and the psychiatrist from your contributor's onslaught. Even the best of us make mistakes, but the cardiologist with a good basic education usually knows and recognises the neurotic anxiety of his patient, while the psychiatrist not uncommonly refers his cases to a colleague to exclude organic disease: in the name of medicine spare our patients from the "group mind instrument". The remedy for the figures of fun described by P.F.S.S. is surely for the medical profession to see that no specialist is recognised without the necessary foundation of the general training.

I am, etc.,

R. S. BRUCE PEARSON.

13, Queen Anne Street,
Cavendish Square, W.1.

Keats and Guy's

SIR,—In his letter of February 19th, 1818, to his friend Reynolds, Keats wrote :—
"It has been an old comparison for our urging on—the Beehive ; however, it seems to me we should rather be the flower than the bee—for it is a false notion that more is gained by receiving than giving—no, the receiver and the giver are equal in their benefits. The flower, I doubt not, receives a fair guerdon from the bee—its leaves blush deeper in the next spring——."

Is it too fanciful to suggest that when he penned this passage, there sounded in Keats' ears the motto—as familiar to him as to us—

Dare Quam Accipere ?

Yours truly,

E.A.P.

September 9th, 1947.

Women Students

SIR,—No doubt there are still those who, with sour looks, will turn a jaundiced eye upon the ladies who are now entering as students into this hospital and will demand, "What is the world coming to ? " as if something really new had happened. The sole purpose of this note is to remind any such sadly misguided gentlemen that the "Civitas Hippocratica" of Europe—the University of Salerno, which was the first great modern medical school and which was already flourishing in the twelth century—admitted women from the start, and not as students only but as teachers too. At Bologna too, which was the second modern school, women already had their rightful position recognised and a young girl, Alexandra Galiani, who, like her counterpart at Salerno, Mercuriada, had a great interest in Surgery, assisted Mondino in the work which resulted in the first modern book on anatomy by one who had actually dissected the human body, the "De omnibus humani corporis interioribus membris Anathomia," of 1316.

For myself, I am glad that this beloved old hospital of ours has at last returned to the noble tradition of its illustrious predecessors.

I am, etc.,

ROBERT C. GREENBERG.

Guy's Hospital, S.E.1.

Students Union

SIR,—As chairman of the Students' Union meeting at which Professor Alfred Blalock spoke, and as the person responsible for what your correspondent, Mr. Thompson, has called "a breach of good manners," I feel that a word of explanation is needed from me.

It is as normal on this side of the Atlantic as it is on the other for a meeting of an organisation to include notices of further comparable activities. This practice is certainly not confined to cinema shows as Mr. Thompson rather oddly suggests, nor are such notices necessarily relegated to the last position on the agenda. It was not intended that the announcements on this occasion should in any way constitute an interruption either by content or timing—and I have no reason at all to think that Professor Blalock regarded them as such. If they appeared to Mr. Thompson and others to do so, I can only offer them my apologies.

I am, etc.,

LEONARD JACOBS.

Guy's Hospital, S.E.1.

Routine A.T.S. Injections

SIR,—Your correspondent, Dr. Nicholson, quotes an example of a fatal case of tetanus following a trivial "breach of surface" for which A.T.S. had not been given.

In a recent lunch time conversation at Guy's, when this subject was discussed, four of us gave a similar experience of tetanus during the last ten years or so. In one case tetanus had followed a small abrasion of the shin on a piece of metal ; in another the "breach of surface" had been caused by a nail in a shoe ; in another it was a small superficial burn on the leg which had become infected. In none of these examples had tetanus seemed the least likely at the time of primary treatment. The unpre-

dictability of tetanus is further confirmed by Cole's analysis of the civilian cases of tetanus in Great Britain between the two wars. These civilian cases were caused by whitlows, burns and a variety of trivial "breaches of surface," in addition to tetanus being a more common complication of more serious injuries.

The argument against the routine administration of A.T.S. to every "breach of surface," however small, is a very reasonable one. It is based chiefly on: the expense in time and in money of the injections; the occurrence of reactions following injection of serum; the low risk of tetanus; and the strong general consideration that specific therapy should be given on definite clinical and bacteriological findings rather than as a routine. For these reasons it has been suggested that A.T.S. should be reserved for only those accident cases which are admitted to the wards.

Against this argument are the facts that: with modern sera reactions are slight and infrequent; that tetanus is unpredictable; that with some 5,000 out-patient "breaches of surface" treated yearly (chiefly from the Boro' with its manure infected dust and dirt), the Hospital would soon see a case of tetanus which might have been prevented; that tetanus is one of the most terrible of diseases which, even with modern therapy, has still a considerable mortality; and that in the event of such a case the Hospital's legal position would be indefensible, if A.T.S. had not been given at the primary treatment.

It would, however, be reasonable to exempt all ex-service personnel from Front Surgery A.T.S. injections, as they may be presumed to have had active immunisation while in the Forces.

I beg leave to sign myself an, on the whole, convinced,

ROUTINE A.T.S. INJECTOR.

Guy's Hospital, S.E.1.

Reviews

A Handbook on Diseases of Children. Fifth Edition. BRUCE WILLIAMSON, M.D., F.R.C.P., Edinburgh. E. & S. Livingstone. 5th Edition. *Price* 15*s.*

ALTHOUGH this little book claims to be a handbook on Diseases of Children, it is more readable than many larger works on the subject. It contains all the pædiatric information required by the earnest but rushed student preparing for the "final" examinations, offered to him in an attractive yet concise form. It is profusely illustrated.

The fifth is essentially the same as previous editions as to form and presentation but has been brought up to date. It includes many advances in therapeutics. The sections on penicillin and streptomycin are particularly well done.

Dr. Williamson is clearly an admirer of Dr. Cameron and the chapters on the functional nervous disorders of childhood are some of the best in the book.

Many rare conditions are given prominence in the text, out of all proportion to their relative importance, but remembering that it is a handbook and not a text-book, this work can confidently be recommended to all those who require a brief, readable and reliable exposition of the basic principles of Pædiatrics.

D. M. D.

The Students' Handbook of Surgical Operations. By TREVES and WAKELEY. Eighth Edition. Cassell & Co. *Price* 15*s.*

THIS well-known handbook has kept abreast of the times and in the new edition the chapters on hernia and amputations have been simplified by excluding operations no longer in general use. New operations on the lungs, heart and nervous system have been added, a timely reminder that knowledge of these branches of surgery is still required of the general surgeon in spite of specialisation.

The lucid descriptions of the common operations have been retained and enhanced by the addition of fifty new illustrations. The concise, well illustrated accounts of the ligation of arteries, the excision of joints, and the performance of amputations will be found invaluable to the Fellowship candidate, but for details of operative technique reference to larger works must be made.

The inclusion of Wheelhouse's description of external urethrotomy has clarified an operation difficult to understand for all who had not seen it performed. In some sections only one operation has been mentioned where there are others with several merits; perineal excision of the rectum alone is described but the simultaneous combined perineo-abdominal operation would seem a worthy and necessary inclusion. At the next revision Bunnell's method of tendon suture, Millin's retropubic prostatectomy and the White Smithwick cervical sympathectomy might well be added.

The student's mind might well be relieved of operations which at present need mention only to be decried and the author is to be congratulated on keeping such references to a minumum and on writing so comprehensive a handbook in so small a compass.

C. P. N.

The Diagnosis of the Acute Abdomen in Rhyme. By ZETA. London. H. K. Lewis & Co., Ltd. 1947. 88 pages, 23 illustrations by Peter Collingwood. *Price* 5*s.* 6*d.*

REJOICE, ye haggard students! Beat the drum!
Blow fanfares on the loud Euphonium!
For here's the book you've needed all the time,
"The Abdominal Emergencies in Rhyme."
(The author, who's best qualified to know it, refuses to refer to it as poetry.)

Of all the subjects that defy analysis
That cannot be reduced to any bally system, that appal us at examinations,
That wreck our disgnostic reputations,
The most exasperating are (or is)
The Acute Abdominal Emergencies.
Here's a fine five and sixpence worth, each feature
Set out by an adept and forceful teacher.
General principles, investigation,
The diagnostic differentiation
Of medical diseases, pancreatitis,
Colics, obstructions and appendicitis,
Tabetic crises, ulcer perforations,
Intussusceptions, twists and strangulations,
Ectopic pregnancies, cholecystitis,
The accidents that cause peritonitis,
All these the author deals with, and the while
Recounts in his inimitable style
Failures, mistakes, the lessons that they taught him
Rather than triumphs and the fame they brought him.
Some of the rhymes are grand, some are so rotten
They can't (like auld acquaintance') be forgotten.
The drawings, done by Peter Collingwood,
Make perfect the superlatively good.

And so we come within a millimetre
Of guessing the identity of Zeta.
Colleague of Moran, Handfield Jones, and Porritt he
Has been for years the world's supreme authority
On urgent surgery, and has striven to show men
The way to Cope with the acute abdomen.

W. H. O.

Clinical Practice in Infectious Diseases. By E. H. R. HARRIES, M.D., F.R.C.P., and M. MITMAN, M.D., F.R.C.P. E. & S. Livingstone, Ltd. Third Edition. *Price* 22*s.* 6*d.*

THIS text-book, described for students, practitioners, and medical officers, achieves its aim in an admirable manner. For practitioners and medical officers it presents a volume of suitable size which deals thoroughly with almost all aspects of their work in the practice of infectious diseases. For the student, this book gets very near the danger of presenting him with too much material for study. Single observations on particular cases of a certain disease, whilst providing very interesting reading, should be viewed by the beginner in medicine in their true perspective and not allowed to

assume too much importance in the mind of the reader. The authors, however, have foreseen this risk and, in their preface, warn the student of its presence.

The first eight chapters deal with general subjects such as Infection and Resistance, Allergy, and the Transmission of Infectious Diseases, whilst the remaining sections present, in full, the features of each disease including its pathology, differential diagnosis, geographical incidence, complications, and treatment. A valuable feature is a short synopsis that precedes each chapter. This provides a very suitable means of revision.

The book is written in a style that makes its contents easy and stimulating to read and, for those who aspire to further study, there are numerous references.

D.H.F.

Biology for Medical Students. By C. C. HENTSCHEL and W. R. I. COOK. Fourth Editiond Longmans, Green & Co., 1947. *Price* 25*s.* net.

THE fourth edition of this well-known text-book has many new features, and the authors are to be congratulated upon the way in which they have made use of the opportunity which arose in 1945 when the entire plant of the book was destroyed by fire.

The botanical section has been re-written with greater emphasis on plant physiology and many excellent experiments are described. The chapter on vertebrate embryology has been re-written and brought up-to-date, likewise the accounts of cell-division, and the structure and life-history of yeast. One is especially grateful to the authors for departing from the customary legend labelling of figures and printing the names of the parts in full.

E.W.B.

Mothercraft in Pictures. By M. MASLEN JONES. Faber & Faber. *Price* 7*s.* 6*d.*

THIS is a well illustrated little book and ideal for the purpose of teaching mothercraft. It will go far to help the young mother to handle her baby correctly and with a sense of security for the child.

L.C.

Biochemistry for Medical Students. By W. V. THORPE, M.A., Ph.D. Fourth Edition. Churchill. Pp. 496. *Price* 18*s.*

IN writing this book, Dr. Thorpe has set himself an almost impossible task. Biochemistry, the study from the chemical standpoint of the life-process, cannot be pruned adequately to fit the needs of any particular class of student; and, in any case, the title raises the questions: "What (or whose) medical students?" "What are they expected to know before and after reading the book?" Naturally enough, the book is unlikely to satisfy teachers whose ideas differ much from those of the author. Dr. Thorpe has interpreted his title in the sense that only *human* biochemistry is of interest to the medical student, but of course, he cannot help departing from this thesis in describing a science so largely founded on observations of animals. It seems to the reviewer that one result of the author's attitude has been to produce a book badly planned, as if the author had not strictly defined, even to himself, the limits of his subject.

The author has also failed to present his physical chemistry in accordance with modern ideas and there are some shocking examples of "paper chemistry" (*e.g.* pp. 75, 153, 192, 298, 310, etc.) in which the author perpetuates such errors, common in too many "biological" text books, as (*a*) that simple salts like NaCl or $NaHCO_3$ can exist to an appreciable extent unionised in solution (*b*) that the sodium ion ($Na+$) is a base and (*c*) that the proportion of HPO_4—to H_2PO_4—in an aqueous solution is subject to some mysterious control rather than being simply dependent on the pH.

Many other errors in presentation can be found in the text. One also regrets the continued use of "steapsin" and "amylopsin," hideous and useless words, best forgotten.

The chief merit of the book lies in its attempt to give the experimental background for so many of the statements made; this, although it may involve over-simplification, should encourage the critical and enquiring habit of mind which physiology has done so much to stimulate, to the great benefit of medical science.

G.A.D.H.

A Synopsis of Anæsthesia. By J. ALFRED LEE, D.A. John Wright and Sons, Ltd. 1947. 1st Edition. *Price* 12*s.* 6*d. net.*

THE difficulties of writing and reading a book of this type are well-known. The author is compelled to summarise, in a relatively small space, all of the known facts and the present consensus of opinion on his subject. There is little room for the discussion of controversial matters, and it is inevitable that some aspects shall appear to have been scantily treated, and that some of the opinions expressed shall appear arbitrary.

Within these limitations, Dr. Lee has performed his task admirably, and he conveys, in a small space, an amount of information which is quite astonishing. He has quite rightly catered for the needs of the occasional, or relatively inexperienced, anæsthetist, as well as for those of the D. A. candidate, and is always concerned to describe a simple method as well as the more complicated ones.

Although, as pointed out above, an author's personal opinions have only a small place in a work of this kind, Dr. Lee's opinions often do emerge, and appear, to this Reviewer, to be admirably sensible. His advice to young anæsthetists on how to learn to use Cyclopropane seemed especially sound, and so did his views on post-operative chest complications.

In reviewing such a concentrated work, it is impossible that one should be able to agree with all the views expressed. Many, for example, will reject the advice given to make a direct injection of local anæsthetic solution into the trachea when anæsthetising for bronchoscopy. Again, the dosage of Curare which is recommended seems from experience to be unnecessarily large. The illustrations which are reproduced from Gray's Anatomy are too small to be of any real use, and one would have thought that it would have been wiser, either to omit them altogether, or better to use specially prepared coloured diagrams. But these are criticisms of minor detail, and do not seriously detract from the very favourable impression formed of the book as a whole.

"A Synopsis of Anæsthesia" is probably too full and too difficult to be useful to the majority of students, but it is clear that it will be indispensible to young anæsthetists and D.A. candidates, and will also form a welcome addition to the library of the more experienced practitioners and teachers of Anæsthesia.

E.H.R.

Sport

LAWN TENNIS CLUB

CUP FINAL

GUY'S *v.* LONDON HOSPITAL.

Result: Lost 9—3.

Played at St. George's Hill, Weybridge, in perfect surroundings, this match was expected to produce a close finish. Our first setback occurred when P. J. Dwyer, our leading player, found that he could not get away from Pembury to play. Even so, we still believed that we could win. After the singles had been played it was still anybody's match, each side having won three matches. After lunch the first round of doubles showed the nature of the opposition for we lost all three matches. The London first and second pairs were altogether too strong for us. Their first pair while being no better than us individually, combined their play better to achieve some really intelligent tennis. In their second pair, R. D. Catterall played tennis a class above ours and his partner fed him well.

We lost the next round of doubles, making the final score 9—3. The match results were :—

Singles : K. M. Hume lost to R. D. Catterall; I. Kelsey Fry beat D. J. Ritchie; E. Searle lost to R. V. Grange; P. S. Carton-Kelly beat I. A. Kellock; R. Merrill beat M. C. Corfield; J. Levenson lost to F. G. Reader.

Doubles : Kelsey Fry and Hume lost to Ritchie and Grange, and to Catterall and Kellock ; Carton-Kelly and Searle lost to Ritchie and Grange, and to Corfield and Reader ; Merrill and D. le Clus lost to Corfield and Reader, and to Catterall and Kellock.

I. KELSEY FRY,

Captain.

GOLF SOCIETY

DENTAL STAFF MATCH.

Another of the popular pre-war fixtures was revived on Wednesday, 24th September, at the Royal Blackheath Golf Club, when the Dental Staff played the Dental Students.

Conditions were ideal and in the first match Mr. Mansie started off in grand style to win the first hole with a " birdie," which considerably upset his opponents. It was a most enjoyable match, resulting in a draw each side winning two matches.

Results were :

STAFF.

Mr. A. Bulleid Mr. J. W. Mansie	1
Mr. W. G. Cross Mr. K. Hooper	1
Mr. K. P. Liddelow Mr. M. Malleson	0
Mr. G. S. Loader	0
	2

STUDENTS.

R. D. F. Thiel J. W. McLean	0
P. S. Holmes T. K. Walker	0
J. M. D. Grant M. J. Quelch	1
N. E. Price	1
	2

GUY'S HOSPITAL CRICKET CLUB

(Season 1947)

September brought the end to a satisfactory and most enjoyable season of cricket, played for the most part in glorious weather on hard, fast wickets. Once more, the climax was the tour in Devon whence the team returned undefeated, a report of which has already appeared.

Again our activities were somewhat hampered by our having to share the ground in August with another club, but it is hoped that the position may be eased in the future.

With the bat, Billingham was at times a pleasure to watch, notably his century against Kenley and his opening partnerships with Holmes were a feature of the later games. Williams, the captain, at No. 3 was consistent and found the wickets to his liking ; Nicholson, with his left-handed style, at times was a useful steadying influence and, later in the season, it was with pleasure that the consistent form of Talbot was noted on his return to the side from the 2nd XI. An eye to his fielding would make the tenure of his place even more certain in the future.

A feature of the play was the maintained excellent form of O'Driscoll on whom, together with Russell, fell most of the hard work with the ball. O'Driscoll's day against South Devon was one of his best feats, 7 wickets for 30, all bowled ; his fielding in the deep was dependable. Russell's figures do not do him merit, he toiled hard and long and produced fine form at times. He also revealed latent prowess with the bat.

The slow bowlers, Nicholson, Woodford and Graham, with their variety of guile provided the side with a powerful attack and considering the type of wicket with which they were provided their results draw their own praise.

The standard of fielding, such an important factor, was variable. At times it was exceedingly high and on an average it may be said to be good. Attention to this department of the game would make up for deficiences in others.

Of the captaincy very little should be said, a separate issue might be set aside for observations by the team. At times, amusement was provided for the sake of team morale by his efforts behind the wickets or with the ball, on which occasion the whole side had ample opportunity to inspect the boundary at close quarters.

Next year, all support from newcomers will be welcomed, and a complete fixture list for two sides is being arranged.

I. D. WILLIAMS,

R. G. NICHOLSON,

Hon. Secs.

House Appointments

NOVEMBER 1ST, 1947 TO JANUARY 31ST, 1948.

GUY'S.

ASSISTANT HOUSE SURGEONS.

To Mr. Massie and Mr. Wass — Mr. R. D. C. Hart
„ Sir H. Ogilvie and Mr. Atkins — Mr. J. V. Kilby
„ Mr. Slesinger and Mr. Brock — Mr. G. F. Vaughan† } *New Appointments.*
„ Mr. Eckhoff and Mr. Blackburn — Mr. J. H. Bayliss†

1. Mr. R. D. Willcock† } *Reserves*
2. Mr. D. H. Forsdick† }

OUT-PATIENT OFFICERS.

Mr. N. B. Finter
Mr. B. V. McEvedy
Mr. J. L. Moffat
Mr. A. G. Parks } *Reappointments.*

HOUSE SURGEONS.

To Sir H. Ogilvie and Mr. Atkins — Mr. G. W. Garland* — *Reappointment.*
„ Mr. Eckhoff and Mr. Blackburn — Mr. E. A. Williams* — *New Appointment.*
„ Mr. Slesinger and Mr. Brock — Mr. J. D. Trethowan* } *Reappointments.*
„ Mr. Massie and Mr. Wass — Mr. J. G. Stebbing }

HOUSE PHYSICIANS.

To Sir J. Conybeare and Dr. Hardwick — Mr. L. J. Evered, Mr. G. J. Hamilton — *Reappointments.*
„ Dr. Campbell and Dr. Hampson — Mr. J. Hart*, Mr. A. W. Banks* — *Reappointments.*
„ Dr. Douthwaite and Dr. Mann — Mr. K. M. Gough*, Mr. A. B. Lee* — *Reappointments.*
„ Dr. Boland and Dr. Baker — Mr. F. R. S. Knight* — *Reappointment.*
Mr. J. R. Trounce* — *New Appointment.*

RESIDENT OBSTETRICIANS.

1.11.47—31.1.48 — Mr. J. Crossley
1.12.47—29.2.48 — Mr. J. M. Hall } *Reappointments.*
1. 1.48—31.3.48 —

CHILDREN'S HOUSE PHYSICIANS.

Mr. G. E. McFall* — *New Appointment.*
Mr. J. Morton Palmer — *Reappointment.*

* Subject to qualification at current M.B. Exam.
† Ex-Service Medical Officer.

NEUROLOGICAL HOUSE PHYSICIAN.

Mr. D. R. S. Saunders*. *New Appointment.*

RESIDENT PATHOLOGISTS.

Mr. T. E. Oppé
Mr. M. B. Conran } *Reappointments.*

THROAT AND EAR HOUSE SURGEON.

Mr. R. D. Willcock†. *New Appointment.*

DERMATOLOGICAL HOUSE PHYSICIAN.

(Non-Resident)

Mr. I. S. Hodgson-Jones*. *New Appointment.*

OPHTHALMIC HOUSE SURGEON.

(Non-Resident)

Mr. P. L. Blaxter*. *Reappointment.*

FRACTURE HOUSE SURGEON.

(Non-Resident)

Mr. P. B. Counsell*. *New Appointment.*

BACK SURGERY HOUSE SURGEON.

(Non-Resident)

Mr. P. F. E. Brown*. *New Appointment.*

ORPINGTON.

EAR AND THROAT HOUSE SURGEON.	Mt. E. H. Couper*	
ORTHOPŒDIC HOUSE SURGEONS.	Mr. A. Brown*	*New Appointment.*
	Mr. M. P. Coplans†	*New Appointments.*
GENITO-URINARY HOUSE SURGEON.	Mr. B. C. Morgan†	*New Appointment.*

JOYCE GREEN.

HOUSE SURGEON.	Mr. D. H. Forsdick†	*New Appointment.*

PEMBURY.

HOUSE SURGEON.	Mr. W. M. Dixon†	*New Appointment.*
ORTHOPŒDIC HOUSE SURGEON.	Mr. J. A. R. Parker†	*New Appointment.*

RESERVES.

1. Mr. J. B. Morrison†
2. Mr. J. E. Mandel†
3. Mr. P. J. F. Walsh†

† Subject to qualification at current M.B. Exam.

*Ex-Service Medical Officer.

October 17th, 1947.

Hospital Information, etc.

NOTICES

DEPARTMENT OF SURGERY.

Saturday, November 8th, Professor Patterson Ross, of St. Bartholomew's Hospital, will be conducting a Departmental Round at 10 a.m.

Monday, November 17th, two Films will be shown illustrating: 1. The Surgery of Hypertension; 2. Shock, at 5.30 p.m. in the Anatomy Theatre.

Tuesday, November 25th, there will be a further Demonstration in the series of Operative Procedures at mid-day.

Saturday, November 22nd, there will be a Clinico-Pathological Meeting in the Anatomy Theatre at 10.30 a.m.

The current Exhibition in the Museum illustrates the Surgery of Neuro-Muscular Inco-ordination.

MEDICAL SCHOOL.

Applications are invited for the appointment of Clinical Assistant in the Department of Diagnosing Radiology. The appointment is for two years in the first instance with attendance on four sessions per week at a salary of £325 per annum. Forms of application, obtainable from the Dean, should be forwarded not later than 21st November, 1947. Duties to commence 1st January, 1948.

GUY'S HOSPITAL STUDENTS' UNION.

The Annual General Meeting of the Guy's Hospital Students' Union was held on Wednesday, October 29th, in the Anatomical Theatre.

In his annual report the retiring Hon. Secretary, Mr. Jack Palmer, noted the increased prestige of the Students' Union within the Hospital, and detailed the wide-scale activities of the past year. These included 3 dances, 7 talks of various nature, the organisation of a secondhand Book Service and of a Students' Blood Donor Scheme, an introductory pamphlet to Guy's for new students, and the acquisition of an office for the Students' Union. The Hon. Secretary also noted the high attendance record at the fortnightly meetings of the Students' Union Council.

The following Officers were elected for the coming year:—

Chairman—Mr. Leonard Jacobs.
Hon. Secretary—Mr. John Walby.
Hon. Treasurer—Mr. John Holden.

During the past fortnight representatives at various stages of study have been elected to the Students' Union Council:—

Medical (Clinical): D. H. Winstanley, D. G. Chalmers, T. B. Brewin, J. H. Evans, B. H. Bass, P. O'Gorman; (Pre-Clinical): J. Palmer, F. J. Covill, R. C. Smith, Miss L. Campion, Miss N. Williams, and J. K. Anderson.

Dental: Dr. B. Wilshere, J. H. Keeling, E. Searle, D. Campbell, P. Holloway, and A. F. Jones.

GUY'S HOSPITAL AMATEUR BOXING CLUB.

The Boxing Club will hold an Open Amateur Boxing Tournament in Aid of the Funds of the Pavy Gymnasium at Seymour Hall, Marylebone, London, on Friday, 5th December next, and an appeal is made to all Guy's men to support the club in their efforts to raise funds for this deserving cause.

Further announcements will be made when the programme is more settled. One of the events will be an inter-team match in which Guy's will be competing.

Early application for tickets should be made to Hon. Ticket Secretary, Appeal Office, Guy's Hospital, London, S.E.1. Telephone: Hop 3334. Prices: 15*s.*, 10*s.*, 7*s.* 6*d.*, 5*s.*, 3*s.* 6*d.*

PASS LIST

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

L.D.S.

September, 1947.

Dental Metallurgy.

D. M. Kent	W. D. V. Ryan
N. J. Mayson	

Dental Mechanics.

C. B. Bowes	G. Narewczewitz
P. Frank	H. A. H. Ohlrich
J. D. Haworth	I. L. Roth
B. A. Hill	A. H. Stocker
M. J. Humphry	H. G. S. Thomson
A. P. Leech	B. R. Venning
A. A. Leigh	G. J. L. Want
J. G. Lloyd	N. J. Wood
E. D. Morgan	

Anatomy and Physiology.

M. F. Ashby	P. D. V. Harrett
J. D. Barker	A. E. Jacques
R. C. Bret-Day	H. I. Levene
W. A. B. Brown	R. R. Lewis
D. W. Campbell	W. C. Porter
A. N. Du Plessis	A. B. Price
P. A. Gardener	W. J. A. Reed
W. J. George	V. G. Rice
H. E. H. Gillett	R. Skaith
J. M. D. Grant	

Special Anatomy and Physiology.

C. B. Bowes	J. C. Leckie
R. C. Curties	A. A. Leigh
V. H. Freiberger	D. J. Murch
P. Griffiths	H. A. H. Ohlrich
J. D. Haworth	M. J. Quelch

CONJOINT BOARD.
September, 1947.
Chemistry.

M. H. Ede	R. M. Saldanha
D. J. I. Jones	

Physics.

G. H. Danford	D. K. Hardy
P. D. Daw	J. A. Mepsted
J. R. Flynn	

Elementary Biology.

P. T. Burla	J. A. Mepsted
G. H. Danford	A. V. Westlake
P. D. Daw	R. B. Whalley
R. E. Lee	

CONJOUNT BOARD.
September, 1947.
Anatomy.

D. M. Devane	I. H. Maine
A. J. Karlish	

Physiology.

D. M. Devane	I. H. Maine
A. J. Karlish	J. M. Stoner

Pharmacology.

S. Adler	K. E. Hodge
S. V. Bhagwat	D. S. Hurwood
G. Canty	M. S. Kataria
P. R. Chalk	E. T. King
A. R. Davis	P. T. C. Rowan
S. S. Grové	E. J. Stafford
J. L. Harrington	R. J. Vale

UNIVERSITY OF CAMBRIDGE.
Michaelmas Term, 1947.
Anatomy.
R. D. Hernaman-Johnson.
Physiology.
R. D. Hernaman-Johnson.
Pharmacology.

J. W. B. Dalgleish	J. O. Ojukwu

CONJOINT BOARD.
FINAL EXAMINATION.
October, 1947.
Pathology.

S. Adler	S. S. Maré
D. A. Ager	J. T. Owen
J. B. F. Boyle	J. D. B. Perkins
P. H. Bright	H. R. C. Riches
M. D. M. Bowen	P. R. M. Scales
P. S. Carton-Kelly	J. D. Scott
A. Goldstein	B. J. Silkoff
F. A. De Hamel	J. S. G. P. Stableford
D. F. N. Harrison	F. B. Sugden
F. R. Lambert	R. J. Vale

Medicine.

S. Adler	F. R. Lambert
A. G. McCallum	*W. E. Macbean
*R. French	E. L. Magee
P. R. Harben	J. B. Morrison
*J. V. Kilby	*D. J. R. Snow

Surgery.

P. H. Bright	*J. V. Kilby
P. S. Carton-Kelly	*R. H. N. Long
*J. L. Hardman	A. J. De Villiers
*A. L. Jeanes	G. H. Warrick

Midwifery.

S. Adler	A. R. Merrill
K. A. Baker	P. T. C. Rowan
P. H. Bright	J. E. Russell
H. M. C. O'Driscoll	W. J. St. E. G. Rhys
E. J. F. Filose	W. F. W. Southwood
J. M. Frisch	C. H. J. Van Aswegan
M. Hutton	G. H. Warrick
E. L. Magee	J. D. Williams

* Have completed the examination.

UNIVERSITY OF OXFORD.
B.M., M.Ch.
October, 1947.
Forensic Medicine and Public Health.

Robert A. Bruce	Bruce W. Cole

GENERAL PATHOLOGY AND BACTERIOLOGY.
William J. C. Symonds.

SPECIAL AND CLINICAL PATHOLOGY.
Bruce W. Cole.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.
October, 1947.
M.R.C.P.

K. D. Allanby	D. N. Leeming
W. H. Bradley	C. A. Rumball
C. H. Edwards	I. McD. G. Stewart
M. F. Franklin	

PAPERS BY GUY'S MEN

Bradley, W. H., and Others. Common Cold. Interim Report on a transmission experiment (Abstract). *Proc. Roy. Soc. Med.*, 1946–7, **40**, 632.

Brock, R. C. Discussion on treatment of non-tuberculous empyema. *Proc. Roy. Soc. Med.*, 1946–7, **40**, 645.

Campbell, Maurice. Paroxysmal Tachycardias (Lumleian Lecture). *Lancet*, 1947, ii, 641.

APPOINTMENTS

Mr. F. N. Doubleday has been appointed visiting Professor of Dental Surgery to the University of Cairo.

Dr. H. R. W. Franklin has been appointed Hon. Anæsthetist to the Royal Victoria and West Hants Hospital.

The undermentioned Guy's men have been appointed to the Wrexham Emergency (County General) and Wrexham and East Denbighshire War Memorial Hospitals.

Physician—J. R. Forbes, M.D., M.R.C.P.
Asst. Physician—P. R. C. Evans, M.D., M.R.C.P.

CHANGE OF ADDRESS

M. J. Blunt, F/Lt. R.A.F., Fairmount, Mottingham Lane, Eltham, S.E.9.

R. L. Canney, M.Chir., F.R.C.S., Bridgeford House, Bridge, Near Canterbury, Kent.

AWARD

The Prince Regent of Belgium has conferred the decoration chevalier of the Order of Leopold II. with Palm, Croix de Guerre 1940 with Palm on Capt. L. G. J. Pitt-Payne, R.A.M.C., in recognition of distinguished services in the cause of the Allies.

Royal College of Surgeons of England.

Mr. Frank Law has been elected member of the court of examiners as Ophthalmologist in connection with specialists' final fellowship examinations.

Royal College of Surgeons of England.

The Hallett prize has been awarded to Dr. Nanalal Jwan Shah.

Territorial Efficiency Medal.

The Territorial Efficiency Medal has been awarded to G. V. Lloyd Williams.

BIRTHS

REWELL.—On October 4th, 1947, at Nuffield House, to Betty Jean (née Willis) and Dr. R. E. Rewell—a daughter (Susan Jane).

SIGGERS.—On October 19th, 1947, at the Howard Nursing Home, Maidstone, to Rosemary (née Serraillier), wife of R. G. Suggers—a daughter (Elizabeth Rosemary), a sister for Suzanne and Mark.

MARRIAGES

REYNOLDS—MORGAN.—On October 18th, 1947, at St. Margaret's Church, Rochester, T. N. Reynolds, M.B., B.S., to Peggy M. Morgan, S.R.N.

Eds. {D.H.F. H.A.R.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LXI. No. 1548 22*nd November* 1947 *Ninepence*

PASSIM

IN the forefront of all our minds, and warm in our hearts as this issue of the *Gazette* goes to press, will be Princess Elizabeth. That warmth will in no way be restrained by the cold circumstances of the times, a hard budget so close behind us, and so close in front of us the prospect of a long bleak winter with less fuel and less food than perhaps this country has ever known. It may be even, that in the darkness of the hour, this second glows the brighter—here at least is a moment for rejoicing.

In the past thirty years or so, marriage has lost so much of its dignity and importance. Vows have come to be made lightly and lightly broken. The home has ceased to be the citadel it was in the life of the nation, and a younger generation is growing up without that security that is inherent in family unity, that safe anchorage in any storm.

It has been attributed to the ever-increasing franchise of women, to the decline in church-going, to a general lowering of morality, the effect of two great wars so close in succession one upon the other. Each has his theory, and few agree, but everyone admits that the state of affairs is to be deplored—and yet the provision of homes is given a most ineffectual priority and women are hastened with increasing urgency from the hearth to the lathe, while homes remain the bricks and mortar and women the corner-stones of family concord. Truly it is to be deplored.

So much the more therefore, in such times, do we wish the Royal Couple all possible happiness. Not only for their sakes is their happiness dear to us, but for the sake of this people. As Princess Elizabeth has followed the precept of her father and her grandfather in the manner in which, clearly seeing her duty before her she has unstintingly performed that duty, so may she, as they did, succeed in her marriage, and as in that, so in this, she will continue to be a paramount example to her generation.

For not until we have returned to a way of living, in which family solidarity is a source of strength, a father's opinion a matter of some moment, and a mother's displeasure a considerable chastisement, will the country which one day she will rule, turn its back on moral poverty and troubled waters.

WE record with regret the death of Frédéric François Burghard, a student of this Hospital from 1881–82. In his years he took a large number of prizes, including the Treasurer's Gold Medal in Surgery, and after taking the M.S., F.R.C.S., and M.D. in rapid succession, was elected to the Honorary Staff of King's College Hospital. He married a Guy's Sister, and besides achieving distinction as a surgeon, was an acknowledged expert in old furniture, and an amateur of renown in the detection of foreign stamp forgeries.

We also record with deep regret elsewhere in this issue, the passing of Arthur Gibbs, since 1919 post-mortem room attendant. Well known to generations of Guy's men, his name has become a word in contemporary hospital language. We hope to publish a more full obituary notice in the near future.

Sister Wharton

AN APPRECIATION FROM ORPINGTON

IN 1943 Sister Wharton arrived at Orpington. There she soon became known as Sister Queen, the title which she had earned during her long years of service at Guy's, and by which she was familiar to many Guy's men. She was placed in charge of Dorcas Ward where she had under her care 30 to 40 patients, mostly service

men and pensioners, with a sprinkling of civilians, suffering from a variety of orthopædic conditions; fractures, gunshot wounds, air-raid injuries, tuberculous bones and joints, knees, feet, arthritic hips, etc. Many sisters with previous orthopædic training might well have been perturbed by the task confronting them, and the wisdom of placing Sister Queen in charge of Dorcas was questioned by many of us. Our anxiety proved unfounded. She quickly settled down, displaying remarkable powers of accommodation for a senior sister, and proved that a sound knowledge of general nursing can be adapted to the needs of a speciality.

Sister Queen soon became familiar with the nursing management of orthopædic conditions, and was quick to appreciate the importance of rest in the treatment of injured joints and limbs. She gave the most scrupulous attention to the dressing of wounds and was successful in achieving remarkably rapid healing and a low incidence of infection. In her detailed knowledge of the medical condition and treatment of her patients, and in her nursing skill she revealed the wisdom which she had acquired through long years of experience.

She also brought to Dorcas the characteristics for which she was renowned at Guy's, and patients and Medical Staff soon learned to recognise certain ominous signs, and to pursue a tactful course. But she had the care and comfort of her patients very much at heart, and despite the severe discipline to which she occasionally subjected them they loved her. She had an intense admiration for the wounded soldier, and was quick to pick out the good types. For the young service men in their late 'teens and early twenties she had a motherly regard, and on one occasion I was rebuked for "taking it out of the young chaps." For the slacker and unpleasant fellow she had no time at all, and as soon as such patients had reached the stage where they were fit to leave hospital, they were quickly made to feel that they were no longer welcome.

To Sister Queen nursing was truly a vocation. The "shorter hours, higher wages" policy of the present day had no attraction for her, and she drove herself and her nurses hard. Indeed she was often heard to remark that she was happiest when she had rather more work to do than she could comfortably handle. She habitually remained on duty until a late hour, and it was with difficulty that she was persuaded to take week-ends and holidays. When the time came for her to retire Sister Queen was loath to leave her post, and we on the medical staff were unwilling to lose her valuable services. We hope that she will find her retirement rather less irksome than she feared, for her great record of service to the sick surely entitles her to some ease and pleasure.

J.S.B.

The Cineplastic and Krukenberg Operations

(with demonstrations by patients from Germany)

A Lecture-Demonstration delivered at Guy's Hospital by
Dr. A. W. J. CRAFT, Research Dept., Roehampton, on March 27th, 1947.

GENTLEMEN,—In introducing this paper and demonstration by patients may I ask you to treat the subject with some reserve, as not suitable for examinations at the present time. Some cineplastic operations were performed in England after the 1914–18 War without success, but it does not appear that any English surgeon has performed a Krukenberg operation; as far as is known.

When you see these amputees demonstrate the final results of each type of surgery you may be tempted to ask why it was not proceeded with in England. I will answer this now, by relating what occurred when these patients saw the modern artificial arms, hands and appliances which are at present supplied by the Ministry of Pensions Limb Fitting Service. Each expressed utmost surprise and astonishment at the dexterity with which amputees, having similar disabilities, used the Ministry prostheses and appliances for general and personal work, and asked why every amputee of all countries could not be similarly equipped. Representatives come from all countries to study

the rehabilitation and equipment of amputees in England, so that it would seem the Ministry provide the best forms of prostheses at present, and still further advances may yet be made.

These German amputees were brought to England under the auspices of the British Ministry of Pensions for a thorough evaluation of the results of the two types of surgery, and to consider if similar work might be considered again in England.

The history of the Cineplastic operation is briefly summarised in an article which appeared in the *Lancet* of February 15th, 1947, page 268, submitted by the Standing Advisory Committee. This Committee was appointed by a former Minister of Pensions to investigate such improvements which might be required in the supply of artificial limbs in England.

Cineplasty is not of German origin. An Italian physician, Vanghetti, published articles in 1898 and 1899. It appears that a Frenchman, Ricard, also wrote upon the subject in 1892. An Italian surgeon, Ceci, collaborated with Vanghetti and ultimately, after experimental work on chickens, produced a cineplastic result upon the lower third of a forearm stump of an amputee in 1905. An orthopædist, Redini, constructed a prosthesis for use by this patient. Many other Italian surgeons became interested in the work on account of the number of Italians returning from the Abyssinian War who had lost both hands in conflict, and from other causes. Many other methods had been tried before some success was obtained, as you will see later.

At first the arm stump was re-amputated to allow the long tendons to pass through the skin at the end of the stump. An endeavour was made to harness these tendons to control a prosthesis on the forearm. This proved a failure, mainly because of sepsis around the tendons. Next a small portion of both the radius and ulna was freed at the distal end with the muscular insertions left intact and the stump closed, with a divided end. This produced a mobile club like a knob on each side of the stump, by which it was hoped to provide a means of attaching some harness whereby the moveable clubs would operate a suitable prothesis. (Fig. 1.) This again did not prove successful. Following this idea, another method was tried by making a slit or loop, through a tendon or a muscle, or between two adjacent muscles with the muscle ends sutured together, to allow a peg to be passed through the loop. The ends of the peg were to be left protruding for harness fixation. The methods of employing a loop through a tendon and of using two adjacent muscles were not successful, but the single loop through one muscle met with some success, and the technique of lining the loop with skin still further advanced the work. Thus the skin tunnel, a better term than a loop, was devised and better results were apparently obtained from the work carried out by Italian surgeons prior to the war of 1914–18.

Apparently about this time work was commenced in Berlin by Sauerbruck who definitely preferred to make tunnels through the muscle substance. It may perhaps explain why this work is often described as the Sauerbruck operation following the pioneer work elsewhere. Sauerbruck did a great deal of cinematisation during the 1914–18 War, and has continued up to, and during, the 1939–45 War.

Cineplasty has been performed in this country and reference is made to the work in *Guy's Hospital Gazette*, 1920, Vol. 54, under the title of " Cinematic Surgery," by W. H. Olgivie. Surgeons in U.S.A., South America,

Spain—during the Civil War, and in many other countries have also obtained good results. Sepsis has supervened in some cases, and is possibly a contributory reason for the disfavour of the operation.

In June last year the Ministry of Pensions sent a number of their Medical Officers to Germany to study the results of cineplastic and Krukenberg surgery, as well as limb fitting in general. Sauerbruck's work in Berlin was seen and we also saw what was claimed to be an improvement of the technique as carried out by Lange at Bad Tulz, near Munich. A plastic motor should have sufficient muscular power, ample range of movement, an appropriate surface for counterpressure covered with well nourished resistant skin. All these desiderata are important but the last condition is most essential. Lange makes a point of freeing the distal ends of the truncated muscles in the cinematised stump to afford a greater range of movement and to give greater power. He also makes a tunnel of greater diameter in an effort to assist the amputee to replace the ivory pegs for himself, and, as he claims, to afford better hygienic conditions in the tunnel than are obtained in one with a small diameter. It was seen that with small tunnels the amputee required assistance to insert the ivory pegs and it has been stated some tunnels were so tightly bound down that the movement was too small to be of use. Whilst in Munich I saw both these statements exemplified.

The surgical technique of the cineplastic operation is described in some books on surgery a recently published book entitled "Cineplasty," by Dr. Henry H. Kessler (U.S.A.), gives a full description with correlated data. Briefly the procedure is :—

1. A three-sided flap of skin and subcutaneous tissue is reflected from the underlying muscle. Each side is approximately two inches (Fig. 2).

2. The opposite sides are drawn together and subcutaneously sutured to form a skin tunnel (Fig. 3).

3. Parallel incisions are made in the muscle and an instrument passed through the superficial third of the musculature (Fig. 4) which can be enlarged to—

4. Draw the skin tunnel through the musculature (Fig. 5).

5. The free end of the tunnel is sutured in place (Fig. 6).

6. The wound is reduced slightly by approximating the corners without tension and the lateral margins are sutured to the superficial musculature.

7. A split thickness graft is laid over the remaining exposed site and sutured.

8. Vaseline gauze is inserted through the tunnel (Fig. 7), and the stump bandaged in the normal manner.

It is the usual custom to construct the skin tunnels on the volar and dorsal aspect of the stump at the one operation. The first dressing may be made in ten days and wood pegs can be inserted in about three weeks. Daily graduated exercises follow with the pegs in place until the prosthesis is fitted from six to eight weeks after the operation. The technique is similar for below and above elbow stumps, and appears to be satisfactory from a surgical aspect in all countries where the work is now done. The main drawback to cineplastic surgery is possibly the prosthesis. I was astonished to see in Germany—a country from where many ingenious devices have originated—the prosthesis now supplied is exactly the same as that made years ago. No attempt had been made to allow the artificial hand to be removed from the arm for appliances

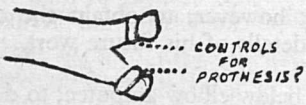


FIG. 1

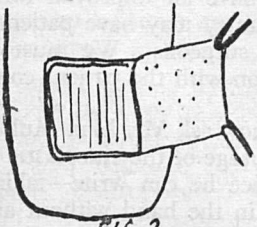


FIG. 2

FIG. 3.

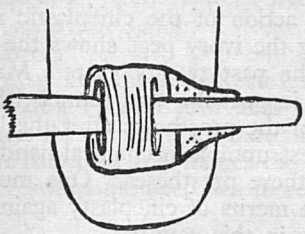


FIG. 4.

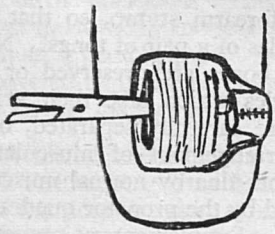


FIG. 5.

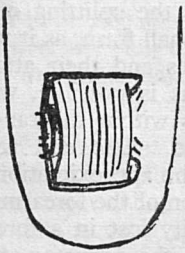


FIG. 6.

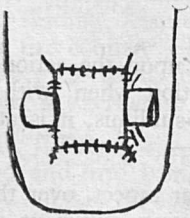
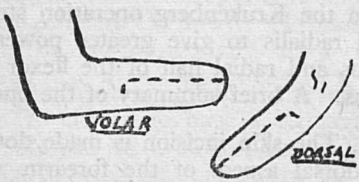


FIG. 7.



KRUKENBERG INCISIONS TO GIVE LARGE ULNA COVER

FIG. 8.

to be used in a similar manner to the artificial arm, as now supplied by the Ministry of Pensions. Work is in progress regarding this matter and maybe when we have an improved form of prosthesis for cinematised stumps we in this country may have patients asking for the operation to be carried out by plastic surgeons. We must be cautious, however, to obtain the closest collaboration with the patient concerning all details of his future work.

I will now ask Mr. Max Muller, a double below elbow amputee, to demonstrate his usage of the cineplastic prosthesis he has worn for over twenty years. You will see he can write—taking the pencil from his pocket, fixing it and locking it in the hand without any aid : he can take a cigarette from a case, a match from a full box, strike the match, light the cigarette : lift a heavy object. He will now remove his coat in order for you to see the flexor and extensor action of the cineplastic motors. Taking off both prostheses, and removing the ivory pegs shows the skin tunnels which have given no trouble during the past twenty years. Mr. Muller does clerical work, and I hope you will inspect the skin tunnels, the prostheses, and his flexor and extensor control of the prostheses after the lecture. May I say here that work is also in progress upon a mechanical hand in an effort to obtain some similar control as with these prostheses. One must not be too hasty in making a decision upon the merits of cineplasty against the normal equipment issued to similar amputees in this country.

I am told the Krukenberg operative procedure is attributed to K. Kron at Bad Hamburg in 1917. It is, as you see, of unusual appearance, being accomplished by the splitting of an amputated forearm stump, so that the radius and ulna shall form, as it were, the two blades of a pair of tongs. Normally the muscles and their attachments to the bones are preserved or reinserted as far as is possible, whilst those muscles which take their origin from both bones within the range of the split are carefully separated, or if necessary divided. The end result of this rearrangement of musculature is to permit of the approximation of the radius and ulna by normal muscular action. Pronation of the forearm is mainly affected by the pronator quadratus, but is of necessity lost in a forearm amputation. Supplementary pronation is obtained from the pronator teres which can also initiate approximation of the radius and ulna but cannot effect a sufficiently strong prehensile function without rearrangement of musculature. Lambret's technique in a form of Krukenberg operation failed by using the pronator teres alone for prehansion without rearrangement of other musculature.

In the Krukenberg operation stress is laid upon the action of the flexor carpi radialis to give greater power of adduction when, with the palmaris longus and radial half of the flexor digitorum sublimis, it is attached to the radius. A brief summary of the operation is :—

1. The skin incision is made down the volar aspect, over the end and up the dorsal aspect of the forearm stump allowing sufficient skin to cover the muscles around the radius (Fig. 9). The area on the inner side of the ulna is covered with a pedicle graft from the chest or abdomen at the conclusion of the operation.

2. The flexor carpi radialis and palmaris longus are held aside over the radius after their terminal attachments are cut away. The radial half of the flexor

digitorum sublimis is similarly treated. The flexor digitorum profundus and flexor pollocis longus are not required as a source of power and can be excised. The median nerve is excised high in the forearm. The flexor carpi ulnaris and the ulna half of the flexor digitorum sublimis are pulled aside to the ulna. All this work is done on the volar aspect.

3. On the dorsal side the muscles may be difficult to separate and they need only be cut through down to the interosseous membrane, which itself is cut through at the ulna border but avoiding damage to the ulna artery and nerve. The radius and ulna are then forcibly separated for the ends to be from 12–25 cms. apart according to the length of the stump.

4. The flexor and extensor muscles around the radius are sutured together and to the radius whilst the terminal ends may be purse stringed over the end of the bone. Those on the ulna side are similarly treated.

5. The skin is closed around the radius, whilst the pedicle graft is sutured to the open area on the inner aspect of the ulna and the arm suitably dressed and held in place on the chest or abdomen for the pedicle graft to " take." When the graft is ready for detachment from the chest or abdomen the operation can then be completed and after various dressings the exercises to rehabilitate the stump are commenced.

Professor Bauer of Heidleburg uses one flexor and one extensor muscle for each bone to reduce the bulk of musculature which is to be covered at the end of the operation. This allows the initial skin incision to be made mesially down the forearm and leaves sufficient to cover both the radial and ulna wounds without a pedicle graft. A small area is left near the cleft of the claws which is covered by a thirsch graft. Both cases you will see to-day have been carried out in this manner by Professor Bauer.

Artificial hands and a form of prosthesis have been made for patients with Krukenberg arms but the difficulties of fitting a useful hand are so great that the double tongs, or claws as they appear, can only be considered useful without an appliance except for this wedge like a pièce of wood which is employed merely as a handle. It is claimed that the specific value of the operation apart from prehensile power is the retention of tactile sensation. It has been suggested this operative procedure might be of value to sightless, double forearm amputees with whom tactile sensation is the dominant factor in relation to their work, reading, leisure, etc. This surgery has not been done on any such person in this country. It has been stated that sightless, double amputees with Krukenberg operated stumps read Braille in Germany. No case was seen in the visit to Germany.

Here is Mr. J. Peters who had a through wrist amputation of the left arm, the right hand and arm being normal. He elected to have a Krukenberg, being unable to obtain an artificial arm. He can lift a book, turn the pages, lift a filled drinking vessel, hold down his drawing instruments in his work as an engineering student and do many other actions quite well. He can firmly grasp heavy objects and can even " stand on the stump ends " without experiencing pain.

Mr. W. Knoop was a double below elbow amputee. Some six months ago he elected to have a Krukenberg operation on one stump and later upon the

other. Both forearms are shorter than Mr. Peters. He must use the wedge shaped piece of wood as a handle for the various objects he wishes to use, such as a shaving brush, safety razor, pencil, spoon, fork, etc. This illustration does not support the claim that Krukenberg amputees need no appliances. Almost all articles used require this wedge-shaped handle.

There is now ample time within this lecture period for you to inspect each patient, and the prostheses. I would like to thank the publishers of Mr. Muirhead Little's book on "Artificial Limbs" and also Mr. Henry Kessler for certain historical and surgical data which I have made use of in talking to you to-day.

In conclusion I am certain you will allow me to express your sincere appreciation, with my own, to the Officers of the Ministry of Pensions who have afforded us this welcome opportunity of seeing these cases to-day, and further in allowing me to make use of some knowledge I learned during my visit to Germany last year.

* * *

During the time which has of necessity elapsed between the date of the above demonstration and my submission of this paper all the patients seen have been fitted with the Ministry of Pensions pattern artificial arms, hands and various appliances. This was deemed necessary for Research purposes to gain knowledge concerning the behaviour of the operation scars and the whole arm stump, if enclosed sockets were to be fitted to any patient after having either a cineplastic or Krukenberg operation performed. Each patient readily became proficient in the use of arms and appliances and suitably expressed their gratitude. Letters have been received from the patients stating that after four months of continued use, and doing much heavier work than formerly, there is no defect upon any scar tissue, no pain experienced and the amputated stumps are in no way adversely affected.

The Arms of Guy's Hospital

By H. St. JOHN RUMSEY, M.A.

SOME months ago when I wrote a short article on our hospital arms I suggested that they should be re-drawn by the official artist at the Heralds' College. This suggestion was adopted and the new drawing has been handed to the Governors; at the same time a line tracing was made from the coloured drawing and this tracing is reproduced below.

In connection with this redrawing, I have heard the phrase—"the new Guy's Arms." It should be clearly understood that it is no question of "new arms" which would not be granted even if we applied for them. It is a matter of re-drawing only, just as much as if a poor sketch was made of our entrance it would be wise to get a new drawing, but this would not necessitate a new building.

It happened that in 1723 when the grant of arms was made to the executors of Thomas Guy, the draughtsman employed was probably the worst they ever had. Not only did he make everything he drew look hideous but he made a blunder in drawing an Austrian Tournament helmet instead of an English Esquire's. Engravers making copies have made the helmet identical with that of a peer, and in one case Thomas Guy was promoted (by the artist) to royal status.

Now all is well and our crest is gracefully grouped on an esquire's helmet at long last correctly drawn. This would seem the right moment to correct our wrong use of a helmet on our blazers. In heraldry the helmet has two functions—to denote the rank of the holder of the arms and—to display the crest fastened to it by a torse or a cap

of maintenance. In the past we have persisted in raising Thomas Guy to the peerage, a kindly gesture but out of place. Secondly, as we do not use our crest on our blazers a helmet perched on our shield is as redundant as the mousetrap carried by the white knight. We are the only teaching hospital with an indisputable right to our arms, so it is a pity to make elementary blunders in our use of them.

Reviews

Synopsis of Surgical Anatomy. By ALEXANDER LEE MACGREGOR. 6th Edition. John Wright & Son, Ltd. *Price* 25*s.*

THE style and form of previous editions of this well-known book have been retained, but the preface points out that Volkmann's contracture has been re-written and the innervation of the bladder has been brought up to date. There might be many who would not agree with the author's interpretation of the pathology of Volkmann's contracture. The nerve supply of the bladder is clearly described, greater functional importance being attributed to the parasympathetic nerves.

It is the practical application of anatomy to clinical and operative surgery that makes the book so valuable and the clear black and white diagrams emphasise the essential features of the text. Here one will discover what is worth knowing in anatomy, why it is important and how to remember it.

The section on congenital errors is of great interest and clarity and the reader will enjoy particularly the anatomy and surgery of the autonomic nervous system.

Perhaps less attention might be given to appendix dyspepsia and so-called primary

sciatica in place of which more detailed anal and broncho-pulmonary anatomy would be welcomed. In certain parts alteration to modern terminology would be helpful.

Students, surgeons and teachers should have this book always at hand. W. G.

Infectious Diseases with chapters on Venereal Diseases. By A. B. CHRISTIE. Faber and Faber, Ltd., London. 324 pages. 1st Edition. *Price* 12*s.* 6*d.*

THIS book is primarily intended for nurses who wish to learn something of the wider aspects of infectious diseases. It is divided into two parts entitled "Clinical" and "Social and Applied" respectively. The former, after a short elementary account of the bacteriological methods available for modern laboratory diagnosis and the ways in which this can be assisted by the clinical and nursing staff, contains some twenty chapters each dealing very adequately with the epidemiological and clinical features of the more important specific infectious diseases. In the latter part, there is a broad discussion of the questions which arise from the application of modern hygiene and prophylaxis to social communities in this country. The problems raised by "carriers," mass immunization, cross-infection, infections in schools and homes, and the social aspects of tuberculosis and venereal diseases are successively considered.

There can be no doubt that this book gives an excellent, up-to-date, account of this important branch of Medicine and Nursing. It provides an admirable introduction to the study of infectious diseases from an unusually broad point of view. The inclusion of chapters upon the social implications of these diseases, especially of tuberculosis and venereal diseases, makes the book a valuable addition to the growing library of "Social Medicine." Although it is described by the author as designed for nurses, it could also be read with interest and profit by most medical students during their Fever Course.

The format is of the now familiar war-time style, but the printing is clear, the type not too small for comfortable reading, and the binding good. G. P. W.

Textbook of Gynæcology. By J. H. PEEL. 2nd Edition. Heinemann. *Price* 21*s.*

I LIKED this book. It is of average dimensions, and deals with the matter to an average depth, but the illustrations and the clarity of exposition are above average. Certain aspects of the subject are particularly clearly and well written. Endocrinological subjects are treated with neither undue enthusiasm nor undue scepticism, which is unusual, and the chapters on symptoms in gynæcology and on therapeutics are very good. At the end of the book, operative gynæcology is described at just sufficient length for a student to grasp the principals, which is length enough. What a pity somebody could not have spent a little longer reading the proofs. The pile of misprints and ridiculous spelling mistakes is inordinately high, highly infuriating. H. A. R.

Textbook of Obstetrics. By G. I. STRACHAN. Lewis & Co. 1st Edition. *Price* 45*s.*

THIS is a large, thorough, well-written and well produced textbook. The author appeals repeatedly for a conservative attitude and a minimum of meddlesome midwifery, which should taste well to the Guy's palate, and he speaks with the voice of experience, not of other textbooks and chair-born theories, but of practical obstetrics. It is a large book of 732 pages, clearly and consecutively set out with few divisions to comfort the unenthusiastic. It is not a book for the student who wishes merely to pass his examinations. The person who is interested in obstetrics, the practitioner who *faut de mieux* has to cope with cases that should be in hospital beds and anyone who wants a reference book of moderate and practical dimensions, would do well to acquire it.

The anatomy and physiology sections are excellent (though on occasions the terminology used for the œstrogens is hardly that commonly accepted) and the advice on the management of normal and abnormal labour (particularly the third stage) savours of real wisdom. What criticisms one has (and one is hesitant to criticise) are largely limited to the occasional recommendations to give pituitary ecbolics before the end of labour, to practice rectal examinations, and the rather aggressive treatment of eclampsia. The treatment of persistent occipito-posterior positions is bold (possibly too bold) and post-partum hæmorrhage and fœtal asphyxia are dealt with less fully than their importance justifies.

But there is no doubt that this is a great contribution to modern obstetric literature.

H.A.R.

Gas and Air Analgesia. By R. J. MINNITT. Baillierè, Tindall & Cox. 3rd Edition. *Price* 5*s*.

THIS little book is primarily intended for the midwife. It contains everything about gas and air that she could possibly expect to learn from a book. Many a student too would do well to read it, containing as it does a description of the common forms of apparatus, with historical notes, some sound advice on the technique of administration in obstetrics and minor surgery, and a wealth of statistical evidence, showing that, used correctly, it works.

H.A.R.

Blind Intubation and the Signs of Anæsthesia. By J. U. HUMAN. H. K. Lewis & Co., Ltd., London. 1947. 3rd Edition. *Price* 10*s*.

TO be able to write a book implies much knowledge of the subject and to publish a book involves the author in definite responsibilities. To me, a hand-book infers a terse version of the generally accepted facts of the subject, while a text-book implies detailed description of the whole subject and may contain personal opinions if these are accompanied by relevant references to the work of accepted observers.

This book is not a hand-book for it does not cover the subject of anæsthesia and is often at variance with accepted anæsthetic opinion. If it is to be classed as a text-book it is again deficient in the qualities expected of it for, as the author states, " I do not know enough of physiology and of biochemistry to be able to follow the experts in their explanation of many phenomena." In consequence of this, his explanations of many of the phenomena of anæsthesia do not agree with generally accepted physiological principles and he fails to produce the evidence necessary to uphold his conjectures.

Under the heading of the " Physiology of Anæsthesia " a description of the mode of action of anæsthetic gases and vapours is given. It is based on the premise that anæsthesia is anoxia, but the various asphyxiation theories of anæsthesia are at variance with and have failed completely to explain many of the facts connected with narcosis and it is consequently unacceptable. The gas laws are ignored and the pressure of an anæsthetic gas or vapour means nothing to the author as the following quotation, whatever its context, indicates : " 0.001% surplus oxygen will be sufficient to keep the blood 95% saturated with oxygen."

The author has little use for the character of breathing as a sign of the level of anæsthetic depression. He states, moreover, that the light reflex as such is of no value to the anæsthetist and maintains that the light reflex is retained until the fourth plane of anæsthesia is reached. I doubt if our anæsthetic clerks would agree with these opinions.

The chapter on blind intubation indicates that the author is adept in this manœuvre and he believes that all anæsthetic subjects should be intubated. One gets the impression from the text that one must intubate at all costs and the text often shows less respect for the larynx than the Ear, Nose and Throat surgeons of this hospital would countenance.

The remainder of this book deals with the Principles of Premedication and anæsthesia in Special Cases. It is an expression of the author's views on the subject and its value is not enhanced by statements such as : " Atropine is said to have some action on the vagus " ; " There is no reason why morphia or omnopon and scopolamine should not be injected intravenously . . . in the dentist's chair " and " Ethyl chloride will never produce those treacherous instances of primary cardiac failure in the second stage of anæsthesia that chloroform does."

It is unlikely that this book could have been written in the critical atmosphere of a clinical teaching school.

T. A. B. H.

Dying, Apparent Death and Resuscitation. By S. JELLINCK, M.D. London, Baillierè, Tindall & Cox. 1st Edition. *Price* 10*s*. 6*d*.

THIS book has a considerable literary interest. Here is an example of Prof. Jellinck's style.

" Although the history and character of these three occurrences differ fundamentally from the emotions described in dying persons—as, for instance, in the very fact that we are dealing with obscure feelings, experiences of the essential ' I ' in healthy, happy persons—nevertheless these occurrences are of significance from our point of view because here—especially in the primitive experiences of two women—the direct,

primary emergence of emotions appears obvious; and further, because here the transformation of emotional excitement into a specific physical sensation and moreover the dynamic causation exerted on the whole organism so presents itself as to be traceable through all its stages." (p. 104.)

Very possibly in the original German such a sentence achieves a kind of mysterious sublimity, like some great mountain that spares but the cloudy border of its base to the foiled searching of mortality; but in English it appears as a string of words with no clear thought to connect them. After reading the translation of any German work one generally has reached this conclusion, that either it must be an extraordinarily clumsy language or else that those who wrote it are indifferent to elegance. Try turning the sentence quoted into Latin and it will crumble away to dust. Now this is a sweet and solemn thought, for without the influence of Latin and the offspring of Latin, French, English might have been very like German.

Prof. Jellinck likes Latin too, but the character of some of the words he uses, such as fæti, anteritatis, momentaneses or calcinosis, shows that he was not really thinking whether Augustus would have understood or not but had his mind rather on ancient medical treatises.

The first part of the book deals with a controversy about real and apparent death which has evidently been considered important in Germany but not, so far, here. Next the Professor conducts us into the realm of German metaphysics, from which the above quoted passage comes, out of a chapter called "Potentialities of the Physician." The matter of this part is no less mysterious than the manner. For instance, he tells of a boy who climbs an electric pylon, receives a severe shock and dies a few days later; but the first action of the lad was to crawl painfully across a meadow and deliver his goats to his mate. There is nothing mysterious to us in this kind and courageous deed, but to the Professor it is "an absolutely incomprehensible bodily movement," and his bewilderment leaves us all groping in a dense fog for two closely printed pages—

crammed octavo pages
Of German psychologics, he
Who his furor verberum assuages
Thereon deserves just seven months wages
More than will e'er be due to me.

The "dynamic causation," I believe, of all the mental gymnastics is a determination somehow to reconcile a very ancient conception of a soul with the observations of modern physiology.

Next follow some interesting remarks on the effect of preparedness on the fatality of severe electric shocks, a discussion on resuscitation and a plea for an international life-saving service. The writing is more perspicuous in this, the more practical part of the book, but it is still over-loaded, repetitive and packed with unnecessary detail, at least according to English taste. For reviving the electrocuted, Professor Jellinck advises Silvester's method of artificial respiration, lumbar puncture and a petrol poultice over the heart. I arise from the book with a pevious conviction re-inforced, that in all Europe the two minds least like each other are the English and the German.

H. St.H. V.

An Atlas of Dental Histology. By EDGAR B. MANLEY and EDWARD B. BRAIN. 1st Edition. Blackwell. Scientific Publications, Oxford. *Price* 12*s.* 6*d.*

THE modest and almost apologetic introduction by the authors to this book should not be allowed to deter the reader. It is refreshing to see dental histology presented in a concise and balanced form, leaving the animals to gnash their interesting but exasperating teeth in the outer darkness. With very few exceptions, all the specimens are taken from human material.

For the photomicrographs there is much praise and very little criticism save that the photograph of von Korff's fibres in the pulp does not give a clear indication of their passage into the dentine. The section on histological technique is a little disappointing; the careless student will not read it, and the student who wishes to pursue the subject of dental histology will find it inadequate. More space could have been devoted to a discussion of the problems of fixation, since this is a very important step in histological technique. Artefacts due to poor fixation are much more likely to appear in sections than epithelial cells from a technician's finger. This is a small criticism, however, and cannot detract from the value of the book to the student who wishes to clarify his mind on a subject often unnecessarily complicated.

Atlas of Bacteriology. By R. CRANSON LOW, and T. C. DODDS; 168 Illustrations, 167 in Colour. Livingstone. Edinburgh. *Price* 32*s.* 6*d. net.*

THIS is a new atlas, and a very good one, coming from the Bacteriology Dept. of the University of Edinburgh, famous for many contributions to the subject in the past. All but one of the 168 illustrations are in colour and the majority derived from actual colour photographs by the Finlay Process. It is hardly to be expected that reproduction would be absolutely perfect, but, compared with the majority of atlases produced in the past, the illustrative value is really high.

Some, who fate has decreed must spend much of their time working with microscopes, may doubt whether it will ever be possible to reproduce on the printed page exactly what one sees through an ocular. Others may hold that the only way to acquire real adroitness in picking up obscure objects under the microscope is constant practice with that instrument and that learning from pictures savours of an examination short-cut. But an atlas as good as this one must silence many critics and it will undoubtedly help students, for whom it is in fact specially designed, to cope with their practical classes, nowadays usually on very short time ration. One particularly important feature should be noted. In recent years many new facts concerning antigenic structure and cultural appearance having come to light, immediate recognition of macroscopic appearances of individual colonies may be most important.

One is glad to see many plates devoted to this phase of bacteriological work, and these illustrations especially should be really helpful to the practical worker. This new atlas is certainly worthy of a place in the Bacteriological library of all teaching hospitals and, if he has a good visual memory and can learn from illustrations, the student will find it a good investment.

F. A. K.

Correspondence

In Defence of Mumbojumbo

SIR,—In your editorial Passim of 8th November, you criticise the present medical curriculum on the grounds that it contains too much that is of little importance to the embryo doctor citing in particular, the "Mumbojumbo of Organic Chemistry," with which it may be inferred, you would include Bio-chemistry as well. While I agree with you that the curriculum contains some deadwood, it does not lie where you suggest; rather should the emphasis be on more pure science and on the acquisition of the ability to conduct reasoned investigation. The Medical Profession would be free of the deadwood of cant and hypocrisy if only this spirit of reasoned investigation had been inculcated into the student from the beginning of his career.

And, Sir, you must admit, that but for the Mumbojumbo of Organic Chemistry the advances in chemotherapy, the knowledge of the action of vitamins and hormones would not have been possible. It may be invidious to point out that but for the body's ability to convert glucose into fructose life would come to a speedy conclusion. It would seem, then, that your escapade with the test tube in the Organic Chemistry laboratory should indeed have left you cold and alas, very little the wiser.

I am, etc.,

P. H. STAPLE.

Guy's Hospital, S.E.1.

Sport

RUGBY FOOTBALL

GUY'S *v.* BEDFORD.

(*Played at H.O.P. on Saturday, 18th Oct.*)

Result: Guy's 9 points; Bedford 3 points.

The match against Bedford, in view of the fine form shown by the hospital, was expected to test our players to the utmost. Guy's came away winners by 1 goal and a dropped goal to a penalty goal.

Guy's played a delightful game, with the forwards once again the dominating influence and although our backs had a monopoly of the ball they could not finish their movements, which were all too orthodox.

P. Rademan, taking the place of A. de Villiers, who is injured, played extremely well, and it was he who scored the try by taking a pass from M. Hatton after P. D. V. Harrett had broken away and made the opening. T. L. T. Lewis converted.

Prior to this, Bedford had taken the lead with a penalty goal by E. Rose.

Guy's were most certainly holding a territorial advantage over Bedford, and justice was done when H. Brunow dropped a goal to complete the scoring.

Team : T. L. T. Lewis, M. J. Gray, F. Retief, F. Le Clus, K. Heber, H. L. Brunow (Captain), P. D. V. Harrett, A. B. Lee, J. H. Keeling, A. N. Du Plessis, A. G. Parks, B. W. Cole, B. Eksteen, M. Hatton, P. Rademan.

GUY'S *v.* ROSSLYN PARK.

(*Played at H.O.P. on Saturday, 25th Oct.*)

Result : Guy's Nil ; Rosslyn Park 8 points

The fixture came about through both sides being without a game, and Rosslyn Park emerged successful by a goal and a try to nil. Incidentally this was the first time this season that the hospital had failed to score.

H. L. Brunow was missing from the side and his place taken by G. P. Billingham, who had been on the injured list for some time.

There were many infringements which rather spoilt the play of the backs, but the forwards, as usual, tackled relentlessly, otherwise the score against us might well have been greater. Much of the play was scrappy but the Park deserved to win by taking advantage of their opportunities.

J. M. Reichwald, the Park captain, scored a try in the first half, which E. Kverndal converted, and close on time N. J. Carver crossed for an unconverted try.

Team : As above except G. P. Billingham for H. L. Brunow.

GUY'S *v.* OLD BLUES.

(*Played at H.O.P. on Saturday, 1st Nov.*)

Result : Guy's 17 points ; Old Blues 8 points.

The Old Blues gave the hospital a much better game than the score suggests, and they made a tremendous rally in the second half which led to a rousing finish. Guy's eventually won by a goal and 4 penalty goals to a goal and a penalty goal.

There were many bright movements by our three-quarters who showed signs of improvement but still failed to take advantage of the many openings that came their way. D. F. Cottier on the right wing played soundly, and it appears that on this form he has played himself into the team.

T. L. T. Lewis opened the score with a penalty goal in front of the posts, and then converted a try by M. Hatton after D. Cottier had kicked ahead and tackled the full-back. Guy's could not cross again but T. L. T. Lewis kicked three more penalty goals, one from near the touch-line. The Old Blues scored a try through D. J. Smith which was converted by G. Smith, and the latter kicked a penalty goal.

Team : As *v.* Bedford except D. F. Cottier for K. Heber and A. de Villiers for B. Eksteen.

HOCKEY CLUB

(Saturday, October 11th.)

GUY'S *v.* NATIONAL PHYSICAL LABORATORY.

(*Played at H.O.P.*)

Result : Won 4—3.

After an unobtrusive war-time existence, the Guy's Hockey Club emerged into the open last season, and was so successful that it only just failed, after a replay in the Final, to win the Hospital Cup. A considerable amount of the credit for this achievement rests with I. Kelsey Fry, who as captain, and in many other ways, worked manfully to put the club upon its feet again. We hope to reap the fruits of his labours this season.

The start, at least, has been propitious. The team included three newcomers, Blake, Jones and Polson-Smythe. The most encouraging feature of the game was that the standard of play was as high as at any time last season. The forwards were in fact considerably improved, but this was offset to some extent by the lack of consideration of the defensive play.

The main criticism of last season, namely, that everyone is guilty of holding on to the ball too long, and not cross passing enough, still holds good. It is significant that the best goal of the team came from a quick cross pass from the left back to the right inside.

It is as yet early in the season to assess our prospects, but judging by the number of new players in the club, and the standard of the trial game, it should be a most successful season.

Team : A. F. Jones, G. H. Danford, H. Carter, J. B. Harris, E. A. Murray (Captain), R. A. Keeble-Elliott, D. V. Duckworth, D. G. Blake, S. S. R. Earl, I. Kelsey Fry, W. E. Polson-Smythe.

GUY'S HOSPITAL FENCING CLUB

The University of London Fencing trials took place at Imperial College on 20th and 24th October. Guy's gained first place in both sabre and épée (Mr. O. F. Conran) and second place in sabre (Mr. H. Wilson), and foil (Mr. H. Ingram).

Of the three matches so far fought, two have been won by comfortable margins

(3 F.E.S. *v.* University College and Hospital, 15—11; 3 F.E.S. *v.* Royal Marines (Deal), 21—6), while the third was narrowly lost (3 F.E.S. *v.* Old Cooperians 12—14).

This term the membership of the club is greatly increased, and new equipment is being obtained. Weapons are scarce, and clothing demands coupons. If any old Guy's men have any fencing equipment, weapons or clothing, which they no longer use, it would be very gratefully received by the Hon. Secretary, Guy's Hospital Fencing Club, London Bridge, S.E.1.

B. L. MALLETT,
Hon. Sccretary.

ICE HOCKEY

GUY'S *v.* HARRINGAY SAINTS.

(Played at Harringay on November 3rd.)

In their first game of the season, the inexperienced and experimental Guy's side did very well to win by 5 goals to 3. During the first period they were nervous and uncertain; this, more than anything, led to Harringays taking the lead with a snap goal after only 45 seconds play. Harringay kept up the pressure and only once in the first ten minutes did Guy's cross the Saints blue line. Good work on the right wing by Olhrich, however, ended when Griffiths scored from an excellent pass. For the rest of the period the Saints were definitely on top and they scored two more goals.

In the second period Guy's were steadier and Grey scored an excellent goal with a shoulder high shot that gave the goal minder no chance. Play was more even now until the Guy's player—coach Charlie Sumner—scored, making it three all. Heartened by this, Guy's continued to press and Grey scored twice; both goals being the outcome of excellent passes from Tucker. In the closing minutes a tiring Guy's team held on well to their advantage.

As a whole, the team played very well, but special mention must be made of goal minder Howe, some of whose saves, especially in the first period, were as daring as they were brilliant. The lack of skating practice was an obvious fault, but the team has good reason to be pleased with its showing.

Team : Grey (Captain), Olhrich, Howe, Watts, Ronchetti, Sheeran, Tucker, Breen-Turner, Annon.

GUY'S BOXING TOURNAMENT

In aid of the funds of the Pavy Gymnasium. At the Seymour Hall, Marylebone, at 7 p.m. on the 5th December. Guy's versus Trinity College, Dublin, 10st. 7lb. Open Intermediate Competition, and four Special Contests. Application for tickets to : Hon. Ticket Secretary, Appeal Office, Guy's Hospital. Prices: 15s., 10s., 7s. 6d., 5s., 3s. 6d.

Hospital Information, etc.

NOTICES.

DEPARTMENT OF SURGERY.

On Saturday, November 22nd, a Clinico-Pathological Meeting will be held at 10.30 a.m. in the Anatomy Theatre.

On Tuesday, November 25th, there will be a further Demonstration in the series of Operative Procedures at mid-day in Theatre 3.

During the first week in December, there will be an Exhibition in the Gordon Museum, illustrative of the Surgery of the Biliary Tract.

DEPARTMENT OF ANÆSTHETICS.

A Revision Course of three Lecture-Demonstrations in Anæsthesia and Analgesia for House Officers will be held on *Wednesdays* in the Clinical Theatre at 2.30 p.m., on *December 3rd*, 10*th* and 17*th*.

GORDON MUSEUM

An exhibition designed to illustrate an analysis of 5,000 cases of Sudden Death from Natural Causes will be on view in the Demonstration Section of the Museum from 1st December to 31st, 1947.

GUY'S HOSPITAL STUDENTS' UNION.

Dr. R. W. Durand, Secretary of the Medical Protection Society, will speak on Tuesday, November 25th, at 4.30 p.m., in the Physiological Theatre, on "Common Difficulties in Practice."

An Extraordinary General Meeting will be held in the Anatomical Theatre on Wednesday, November 26th, at 2.15 p.m., to discuss affiliation to the British Medical Students' Association. A referendum on this subject will be held during the following week.

JOHN C. WALBY,
Hon. Secretary.

STUDENT HEALTH SERVICE.

From Wednesday, November 12th, the weekly Student Out-Patient Clinic will be held on Wednesday at 2 p.m. in the T.B. Out-Patient Department, 1st Floor, Out-Patient Block, instead of on Saturday morning in the Pre-Clinical Classroom. Appointments should be made as before with the Secretary, Extension 297, or Hop 3500, Ext. 15.

THE OSLER CLUB OF LONDON IS TO REVIVE.

The Club was founded in 1928 with the double object of encouraging Medical Students to link the history of their Art with their professional work, and to keep green the memory of Sir William Osler, Pre-war members will form the nucleus. They wish to add to their numbers interested Medical Students or recently qualified men and women. Further details may be had from the Acting Secretary, Dr. A. White Franklin, 11, Wimpole Street, London, W.1.

CHRISTMAS CARDS AND ETCHINGS.

The following Etchings by Mr. Hansly Fletcher are still available: The Park and Front Gates at 3*s.* 6*d.* each (post 6*d.* extra), and a few Christmas Cards at 6*s.* 6*d.* per dozen (post 6*d.* extra).—Apply: The Manager, Gazette Office, Guy's Hospital.

PASS LIST

UNIVERSITY OF LONDON.

THIRD (M.B., B.S.) EXAMINATION FOR MEDICAL DEGREES.

October, 1947.

PART I.

K. Anderson	K. B. Kenyon
D. S. G. M. Bailey	J. E. H. Lahaise
A. S. Bligh	R. A. Miller
A. W. Cook	C. P. Mills
H. E. F. Davies	J. T. Owen
C. J. Earl	H. R. C. Riches
R. L. Gothilf	P. Ronchetti
E. W. Graham	B. J. Silkoff
R. D. C. Hart	K. Simpson
J. L. Herbert	C. W. Taylor
H. D. A. Hope	R. J. Vale
J. S. Jones	P. R. Wagner
R. A. Keable Elliott	A. W. R. Williamson

PART II.

P. W. Edward	A. B. Wayte
M. J. May	

PART III.

J. B. Eades	A. L. Jeanes
C. N. d'E. Eastes	J. Southgate
P. R. Harben	J. A. Sutton

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

F.R.C.S.

PRIMARY EXAMINATION.

I. D. Henderson	C. H. J. Rey
J. T. M. C. Jenkins	E. A. Williams

SOCIETY OF APOTHECARIES OF LONDON.

FINAL EXAMINATION.

October, 1947.

Pathology, Bacteriology and Forensic Medicine.

D. M. Strange

Medicine.

D. M. H. Bickmore — C. H. J. Van Aswegen

Midwifery.

D. M. H. Bickmore — C. H. J. Van Aswegen

PAPERS BY GUY'S MEN

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Wheatley, D. P. Vitamin K for the relief of chilblains. *Brit. Med. J.*, 1947, ii, 689.

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ROYAL SOCIETY OF MEDICINE.

C. Worster-Drought has been elected President Neurological Section, Royal Society of Medicine, 1947–48.

CHANGE OF ADDRESS

H. Gordon Ryder, L.D.S., R.C.S., 45, Matai St., Riccarton, Christchurch, New Zealand.

Professor G. Stead, "Golden Hawe," Bears Den, Kingswood, Surrey. (Tel. Mogador 2786.)

BIRTHS

NANCEKIEVILL.—On October 31st, 1947, at the Jessop Hospital, Sheffield, to Dorothy (née Hesslegrave), wife of Leslie Nancekievill, M.D., M.R.C.P.—a second son.

PLOWMAN.—On November 11th, 1947, at Nuffield House, Guy's Hospital, to Pearl (née Burt), wife of R. David Plowman, L.D.S., R.C.S.—the gift of a daughter.

MARRIAGES

MOTE—FLOWERS.—On November 15th, 1947, at All Saints Church, Dovercourt, by R. M. Mote, L.D.S., R.C.S., to Rita J. Flowers, S.R.N.

DEATHS

BURGHARD.—On October 31st, 1947, Frederic F. Burghard, C.B., M.D., F.R.C.S., of Fen Causeway, Cambridge, aged 83 years.

GIBBS.—On November 16th, 1947, Arthur E. Gibbs, loyal servant of Guy's Hospital since April, 1919, aged 64 years.

WEBBER.—On October 26th, 1947, Alex. Moxon Webber, M.S., M.B., B.S., F.R.C.S., Sandown, Isle-of-White.

Eds. { H.A.R. —

GUY'S HOSPITAL GAZETTE

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PASSIM

A LITTLE while back, everyone was talking of "The New Guy's." Plans were flourished, models were exhibited, and withall there was an air of expectancy and optimism. One felt that within the year a great edifice would surely rise like the phœnix from the ashes across Maze Pond. But that has quietly died. We are mending and making do again.

A lot has been done, much is under way, and more is to come. The York Clinic, The New Pathology Block, The Medical School and Nuffield House were materially little affected by Hitler's escapade. Hunt's House lost its staircase and a few rooms near the roof, but the wards offer the full pre-war accommodation. With the staircase, however, went the lifts, and although one has been in use again for some time, albeit intermittantly, the larger of the two is still in the final stages of repair, and as soon as it is finished, the small one will be de-commissioned for a thorough overhaul. In time it is hoped to have a third lift in this block, and moreover to make use of some of the wasted space on the landings.

In the Surgical Block, on the ground floor, Martha has been converted into a new Counting House. Dorcas has been renovated. On the first floor what is left of Keats, which is precious little, has become the offices of the *Gazette* and Guild of Ex-Patients, and Astley Cooper has within the last month been re-opened. At present it houses the gynæcological beds, which soon will be moved again to the new hut nearing completion in the front quadrangle, on the site of the Superintendent's House and the old Counting House. It looks dreadful but it will have twenty beds. On the next floor, Christopher will be brought back into use in the near future. Job and Luke are as they were, and the remains of Naaman will become the Central Surgical Supply Room. Under the eaves, Pat and Sam are still the same, perhaps a shade brighter, and Evelyn is no more. Underground, Esther, with modifications, has become the offices of the Department of Obstetrics and Gynæcology and Anæsthetics.

Alterations are likely to come in the Out-Patient Block. The transfer of Surgical X-Rays to the little used space at the end of the main hall, beside Medical X-Rays, is under consideration, a small unit only being left behind to do the work of the surgical block. The Medical Registrar's and O.P.O's. out-patients would in that event be housed in the neighbourhood of the present back-surgery, and back-surgery would be completely re-formed, with a separate entrance, possibly in the large basement room, which during the war served as an operating theatre. The fracture clinic and the minor ops theatre would also be re-organised at this end of the building.

Addison has a completely re-furnished, re-designed sanitary block, which not before time and at last, might reasonably be called sanitary, and this benefit will soon be extended to other wards. Another improvement in the offing is the wiring of plugs by the beds to take wireless headphones offering a choice of three stations.

On the administrative side a great advance is soon to be made in the system for calling hospital staff. The present method whereby the college porter is left to chase the take-in Residents on the house telephone is as time consuming as it is inefficient. Shortly, frames of five coloured lights will be fitted at vantage points throughout the hospital, calling anybody who is wanted, to the telephone, when by ringing the exchange he will receive his message. It is possible also that outside calls may be put through directly on the internal system.

All these reconditionings and renovations require much labour and material, of which the latter (and the necessary official permits to use it) are the more difficult to acquire at the moment, but considering the hard times and the delays imposed by official procedure, a great deal has been accomplished. It is by no means as we would have it, but at present there are four hundred and seventy beds in use, soon to be increased to over five hundred, and Old Guy's men will find the place looking much as it always has done—in corners much better. The works department, without whom truly this hospital could not stand, are to be congratulated on the soundness of their

work. It is indeed gratifying to find them so completely uninfluenced by the vogue of shoddiness which seems to predominate elsewhere in their line of business.

WE report, with very deep regret, the death of two ex-Guy's nurses in India.

Madeleine (Biddy) Clarke was a trainee 1931–1935, who returned as a staff nurse for a while in 1938, and married Col. Dykes in India shortly afterwards. She and her husband were shot by tribesmen in Kashmir, a few days after the birth of their third child.

Olive Percival, at Guy's 1931–1934, took up missionary work in India, and while on leave only a year ago came back here as a relief holiday sister. She too was shot.

We would extend to the relatives of both these nurses our deepest sympathy in their great and untimely loss.

WE welcome Dr. A. Angus, T.D., M.D., who has been appointed Admitting Officer to the Hospital as from 8th December, 1947. Dr. Angus, at one time a General Practitioner in Newcastle, served in the Army during the war and commanded a General Hospital in Egypt and Italy, where he met and worked with a number of the present Guy's staff. His post will entail taking charge of the Reports Registry and the statistics which come from the reports, and superintending admissions to the Hospital during the day. We feel sure that this will be appreciated by General Practitioners trying to find beds for patients, particularly as they will be contacting a man with experience in their particular branch of medicine, and its peculiar difficulties.

WE bid farewell to two well-known Guy's characters, Dr. E. B. French and Dr. Brian Johnson. Dr. French has enhanced the already illustrious name he bears by his teaching of medicine as a Registrar here, and very many people will deeply regret the loss which medical teaching has to sustain by his departure to take up the appointment of first assistant in the Medical Unit at St. Mary's. Dr. Johnson, who has been Anæsthetist and Deputy Superintendent at Orpington, goes to be Anæsthetist to the City General Hospital, Leicester. His wit and personality will be missed at the County Hospital, as will be his narcosis.

WE regret to announce that D. H. Forsdick, Editor of the *Gazette* since 1st September, 1946, having qualified at the recent London Final Examinations, has been posted to Joyce Green, and finding it impossible to retain the editorial chair, has handed in his resignation. At a meeting of the *Gazette* Committee, R. A. Keable-Elliott, in his final year of studentship, was appointed Assistant Editor. We welcome him with open arms and a dearth of ideas.

Guy's Diary

DECEMBER

ACADEMIC

5th. Surgical Dept. Current Exhibition in Gordon Museum. "Surgery of Biliary Tract."
13.00. Clinical Lecture. Dr. Hampson. "Jaundice."

8th. 13.00. Clinical Lecture. Dr. Evans. "Diagnosis of Mental Deficiency."

9th. 12.00. Neurological Demonstration. Sir Charles Symonds.
12.00. Surgical Dept. Further Demonstration of Operative Procedures. Th. III.
16.15. Endocrinological Demonstration. Dr. Bishop.

11th. 16.30. Current Radiological Cases. Dr. T. H. Hills.

12th. 13.00. Clinical Lecture. Mr. Brock. "Dysphagia."
14.15. Medical Dept. Combined Round

13th. 10.00. Surgical Departmental Round. Prof. Grey Turner.

15th. 13.00. Clinical Lecture. Mr. Young "Acute Otitis Media."

18th. 13.00. Clinical Lecture. Dr. Bishop.

19th. 13.00. Clinical Lecture. Dr. Mann.

SPORT and SOCIAL

15th. Aft. and eve. Rifle Club. President's Prize. Monthly Spoon Comp.
19.00. Open Amateur Boxing Tournament. Seymour Hall.

6th. Rugby XV. *v.* Swansea (Home).
Association XI. *v.* London Hospital (Home).
Hockey XI. *v.* Inland Revenue (Home).

9th. 13.00. Music Club. Gramophone Recital. Path. Class Room.

10th. Association XI. *v.* R.M. Chatham (Away).

11th. 16.30. Physiological Soc. Paper "Brain Wave." Mr. D. B. Amos.
17.00. Dental Soc. Paper, "Some Aspects of Private Practice." Dr. B. H. Wilshere. Dental Th., Old Path. Block. (Tea 4.30).
21.30. Music Club. Gramophone Recital. Nurses' Home.

12th. Aft. Rifle Club. Monthly Spoon Comp.
Eve. Rifle Club *v.* London Hosp. (Home).

13th. Rugby XV. *v.* Old Cranleighans (Thames Ditton).
Association XI. *v.* Hendon (Home).
Hockey XI. *v.* Met. Police (Home).

15th. 18.30. Fencing Club (4 foils) *v.* Toynbee Hall (Home).

16th. 13.00. Music Club. Gramophone Recital. Path. Class Room.

17th. Association XI. *v.* City and Guilds College (Home).
19.45. Music Club. Concert. Phys. Th.

18th. Eve. Rifle Club *v.* Imperial College (Home).
21.30. Music Club. Gramophone Recital. Nurses' Home.

19th. Aft. and Eve. Rifle Club. Monthly Spoon Comp.

20th. Rugby XV. *v.* Moseley (Moseley).
Hockey XI. *v.* West Herts (Home).

Epilepsy

A Clinical Lecture delivered by HENRY COHEN, M.D., F.R.C.P., Professor of Medicine, University of Liverpool, at Guy's Hospital, October 16th, 1947.

GENTLEMEN,—To be invited to deliver a clinical lecture where a century ago lived and worked the " great men of Guy's "—Bright, Addison, Hodgkin and others—is a signal honour. But the lustre is a little dimmed by the responsibility, and it is in no sense of mock modesty that I make prior apology for my shortcomings.

I have chosen " epilepsy " as my topic, not solely for its intrinsic interest as one of the most dramatic clinical episodes we doctors are called upon to witness, nor primarily for its importance as a community health problem though 1 in 250 of the inhabitants of this island suffer from epileptic attacks, but especially because it illustrates simply and clearly the modern approach to medicine which it is essential should be inculcated at an early period of our clinical training if, as is generally agreed, education should be primarily concerned with forming habits of thought and not with spoon-feeding a student with facts.

The first general point I would make, and it is one which though self evident is not widely appreciated, is that names exist as convenient symbols to convey notions or ideas, and that though the notion alters as our knowledge develops the name often remains the same. The ideas conjured up by the word " atom," for example, were very different for Lucretius, for Dalton, and for the modern physicist. So it is that the term " epilepsy " conveyed a notion to our forefathers quite unlike that which it carries to-day.

The earliest conception is bound up with the older notions of the nature of disease. The ancients wrote of " diseases " as if these were entities implanted on the healthy body where they wrought their evil. " A disease " was regarded as the outward expression of an " evil spirit "—a " demon "—invading the body; it was to be exorcised by prayers, doggerel rhymes, amulets, or potions, and its expulsion might be aided by creating an exit for it from the body, hence the ancient practice of trepanning. This conception of " disease " as " entities " was further strengthened by the writings of Sydenham—the English Hippocrates. He was influenced by Linnæus' classification of animals and plants into separate and defined species, believed to have been created as such in the beginning. For Sydenham diseases were " to be reduced to certain and determinate kinds, with the same exactness as we see it done by botanic writers in their treatises of plants," and possessing " certain distinguishing signs which nature has particularly affixed to every species." In this way " diseases " were catalogued and their pathognomonic signs were sought; the patient was observed and examined; the symptoms and signs he presented were compared with those described in the books, and the " label " which appeared most closely to conform to the clinical picture he presented was attached to the patient as a " diagnosis." Thus it was that various types of epilepsy—the major attacks with transient unconsciousness and convulsions, the minor attacks with unconsciousness but no convulsions, the focal motor types with local convulsive movements but no loss of consciousness, and many others—were and still are described as " diseases " in our text-books. To-day, however, our outlook on disease is reorientated to conform to our wider and

deeper understanding of its nature. We recognise that disease represents disturbances of normal structure and function by pathogenic agents, both physical and mental, and that only by an understanding of normal structure and function can we discern the significant mechanisms of disease.

Thus what we term " epilepsy " is not " a disease " ; it is not an " entity " which exists by and of itself. It is the expression of a disordered functioning of nerve cells in the presence of disturbing influences, both extrinsic and intrinsic. To understand its nature we must know something of the normal function of the nerve cell.

From the store of energy in our nerve cells there is a constant, orderly and regular, moderate and controlled discharge. Objective evidence of this is found for the cortical cells in the electro-encephalogram. Normally, say from the occipital cortex, can be registered a regular series of smooth waves which appear at a rate of about 10 per second ; this is called the *alpha* rhythm. Other waves labelled *beta*, *gamma*, etc., may also be normally observed. In sleep the electro-encephalogram is composed almost entirely of slow waves (the *delta* rhythm) which vary in frequency from 1–6 per second. But in epileptics and in the victims of other cerebral lesions, waves of abnormal frequency, amplitude and rhythm may occur. These do not always produce observable changes at the end organs of the neurones, *e.g.* the muscles ; such masked disturbances of rhythm are often found in known epileptics and in the relatives of epileptics, but as they give rise to no clinical disturbances they are labelled " subclinical." But in epileptiform attacks of all types—grand mal, focal epilepsy, psychomotor epilepsy, and others—gross changes in the electro-encephalographic pattern are found which signify that there occur at the time of the fits, sudden, explosive, uncontrolled and often irregular and excessive discharges of nerve energy from the cells of the whole or localised areas of the cortex. Hence through the Greek conception of epilepsy as " a taking hold of, a something seizing the subject as though that something were outside himself," through the idea of " epilepsy " as a disease with many variants such as grand mal, petit mal, etc., we arrive, on the basis of modern cerebral electro-physiology, at the view that " epilepsy " represents a *paroxysmal cerebral dysrhythmia* due to abnormal and excessive neuronal discharge.

From this we may infer that all nerve cells of central, peripheral and sympathetic origin may show " epileptic " phenomena. I shall discuss later the well recognised motor and sensory types of cortical epilepsy ; but are we not dealing with analogous states in other paroxysmal dysfunctions of the nervous system ? We know that in lesions of the hypothalamus attacks of sudden flushing, tachycardia, sweating, salivation, lachrymation and other evidences of autonomic disturbance—the so-called " diencephalic epilepsy "—may occur. May not spasmodic torticollis and torsion spasms result from similar " discharging " lesions ? Does not trigeminal neuralgia suggest an explosive neuronal discharge from cells in the Gasserian ganglion or sensory nucleus of the 5th cranial nerve ? And can we explain paroxysmal unilateral sweating and flushing, mydriasis, stare and exophthalmos on any basis other than an epileptic discharge from the cells of the superior cervical sympathetic ganglion ? Is not the fibrillation of muscle seen in degenerative lesions of the anterior horn motor cells an analogous phenomenon ? The evidence is strong in its favour and suggests that a whole series of paroxysmal neural disturbances hitherto thought to be unrelated, have a common disorder

of function, viz., the sudden, uncontrolled, explosive and excessive discharge of neuronal energy.

The tendency to such abnormal discharge will depend upon two factors: first, the inherent stability of the cells, for which we may coin the term "epileptogenic threshold"; and secondly, the intensity of the disturbing factor or "epileptogenic agent." The occurrence of clinical epilepsy will be the outcome of the interaction of these two factors. The more unstable the cell or the more intense the stimulus the greater will be the tendency to epilepsy; but even a normally stable cell may, under the influence of a sufficiently potent epileptogenic agent, give rise to epileptiform attacks.

The "epileptogenic threshold" will depend in part, as do other individual characteristics, on inheritance. There will be, that is to say, familial tendencies to unstable energy mechanisms in nerve cells, just as there are in other tissues to diabetes mellitus or to premature greying of the hair; hence the marked inherited tendency to epileptic attacks. But the various cells of the nervous system will exhibit individual differences in the ease with which they "explode." We should expect that the older cells, *e.g.* those of the hypothalamus and red nucleus, would be more stable than the cortical cells which are a more recent acquisition in evolution. The frequency of cortical epilepsy as compared with say diencephalic epilepsy supports the view that neuronal stability is greater in cells of older phylogeny.

Various methods have been devised to determine the epileptogenic threshold. The dose of such convulsant drugs as camphor and cardiazol needed to produce an epileptic attack may be determined and compared with known normals. The effects of water retention by giving water and a standard dose of pituitrin may be observed. The level at which insulin hypoglycæmia produces convulsive movements may be explored though it is not without risk. The effects of hyperpnœa, of electrical stimulation of the brain, and of cerebral anæmia induced by bilateral carotid pressure are other means of showing the individual variations in epileptogenic thresholds, though too great reliance should not be placed on small quantitative differences.

There are three groups of causes acting on the nerve cell which may facilitate the epileptic discharge. Firstly, an afferent nervous stimulus; for example a loud noise, a bright light, a sharp blow, or an electric shock, may act as "detonators." This occurs especially when the epileptogenic threshold of the cell is low. Secondly, intracellular disturbances resulting from disease; in this category are included all intrinsic pathological processes which derange cell metabolism; thus structural changes, be they congenital, inflammatory, degenerative or neoplastic; anæmia or cyanosis, or vascular changes which result in these; toxæmias, *e.g.* uræmia, alcohol, absinthe, pneumonia; allergy; hypoglycæmia; deranged phenylpyruvic acid metabolism, etc. The cardinal fact is that any change in the cell's structure or function threatens its stability and may lead to epilepsy. Thirdly, the functioning of nerve cells is dependent on the integrity of other neural systems which may exert a stabilising influence on the discharge of nerve energy from the cell so that when these systems are disturbed the cell discharges irregularly. This, too, might give rise to epileptic phenomena as, for example, in decerebrate rigidity.

A further fact must be noted if the mechanism of epilepsy is to be appreciated, namely, that the abnormal neuronal discharges spread in two directions: first along the efferent paths (axones) of the nerve cells from which they arise thus

giving the normal end reactions, *e.g.* muscle contractions from a motor nerve cell, visual phenomena from cells of the occipital visual cortex, or sweating and flushing from sympathetic cell stimulation; and, secondly, the abnormal discharge may spread through dendrites, and cause analogous abnormal discharges in contiguous cells of the brain until wide areas and possibly the whole of the cerebral neurones are thus discharging.

Those who rightly revere the memory of Hughlings Jackson would regard it as unpardonable if I did not refer to his prescient genius, for long before the era of electro-physiology he had postulated on the basis of clinical observation that " a convulsion is but a symptom and implies only that there is an occasional, an excessive, and a disorderly discharge of nerve tissue on muscle. This discharge occurs in all degrees: it occurs in all sorts and conditions of ill-health, at all ages, and under innumerable circumstances." " I have always assumed and shall continue to suppose that convulsion results from excessive discharge of nerve cells, meaning, of course, liberation of energy during rapid decomposition (katabolism) of some matter in, or in part of those cells. I shall frequently speak of cells concerned with excessive (primary) discharges as constituting a ' discharging lesion.' "

It follows from what has been said that any classification of epilepsy should be based (1) on clinico-anatomical considerations or (2) on an etiological basis, and that the significance and purpose of these should not be confused.

The clinico-anatomical classification is best approached by a description of the classical grand mal or major attack. In its complete form four stages are observed :—the aura, the tonic stage, the clonic stage and the post-ictal (ictus=a stroke) state. Adequate descriptions of these are to be found in most text-books, so I will emphasise but a few salient points. The aura indicates the seat of the initial discharge and so it may be of any type—psychic, motor, sensory or visceral. But wherever the commotion originates there may later occur a general spread which expresses itself by the tonic stage (with its cry, cyanosis and apnœa), the clonic stage (with its urinary and fæcal incontinence) and the post-ictal state. As a result of the explosive discharge of its energy the nerve cell may be left exhausted and thus paralytic phenomena ensue. This paralysis of the higher centres might in turn give rise to release phenomena at lower levels causing post-ictal automatisms. Moreover, during the course of recharging, the cell may be unstable and ' explode ' more readily, hence the frequent occurrence of repeated epileptiform attacks—*status epilepticus*. This describes the ' whole ' attack but partial fits of all degrees and types are seen, in various combinations which may begin or cease at any stage of the complete ' grand mal ' attack.

It is moreover important to recognise that the attack itself may obliterate its subjective components from the memory as, for example, in the apparent absence of an aura previously experienced, due to a retrograde amesia.

Table I (after Penfield) proposes a classification of the main clinical types of epilepsy based on the foregoing considerations and relates them to their anatomical basis.

Occasionally for a period lasting a few hours to a few days the epileptic is aware that an attack is imminent. The " prodromata " include headache (which may be due to local cerebral congestion), excessive appetite or thirst, an exaggerated feeling of well-being, and many others whose mechanisms are as yet ill understood.

TABLE I.

CLINICO-ANATOMICAL CLASSIFICATION OF EPILEPSY.

	Type.	*Site.*
A.	*Motor.*	
1.	Generalised (Grand Mal)	General
	a. Status epilepticus	
2.	Jacksonian (Focal Motor)	Precentral gyrus
	a. Conjugate eye movements	Area 8 (anterior to precentral)
	b. Masticatory	Lower Rolandic
	c. Myoclonic (Unverricht)	
	i. Epilepsia partialis continua (Kojewnikow)	Precentral or spinal
3.	Simple adversive	Frontal
4.	Tonic, postural (decerebrate)	Brain stem
5.	Inhibitory (akinetic)	Precentral
B.	*Sensory.*	
1.	Head, trunk and limbs	Precentral
	a. Continuing sensory seizures	
2.	Special senses	
	a. Visual	Occipital
	b. Auditory	Temporal
	c. Vertiginous (" dizziness ")	Temporal
	d. Olfactory	Uncinate (infratemporal)
3.	Tics.	Sensory nuclei (trigeminal, glossopharyngeal, Sluder, post-herpetic)
C.	*Visceral.*	
1.	Autonomic (epigastric discomfort, palpitation, micturition, sweats, flushing, nausea, fear, pupillary changes, etc.)	Hypothalamus
	a. Vaso-vagal attacks (Gowers)	Medulla
	b. Unilateral paroxysmal sweating, etc.	Sympathetic ganglia
D.	*Psychical.*	
1.	Dreamy states, illusions, hallucinations ; déja vu (? sensory)	Temporal and frontal
2.	Petit mal (often combined with mild motor phenomena)	
	a. Pyknolepsy	
3.	Automatism	
	a. Ictal (psychomotor, epileptic equivalents)	Frontal
	b. Post-ictal	Lower levels (release)

There are many types of epilepsy described in terms which simply indicate the precipitating factors, *e.g. reflex epilepsy* in which a stimulus such as slapping the face will excite an attack and of which special examples are *musicogenic epilepsy*—where a tune, and *acoustico-motor epilepsy*—where a loud noise, precipitates the attack. Psychogenic factors, *e.g.* a sudden shock or emotional upset, may excite a fit and it is to this that the term " *affective* " or " *psychic* " epilepsy is applied. Nor must the effects of reflex and psychical factors in arresting attacks be forgotten. Galen recorded that tying a string around the limb affected at the onset, would arrest an attack and many patients describe how by an effort of will directed to focussing their attention sufficiently early in an attack on some remote thought or situation, the fit is often aborted.

The epileptic attack is a distinctive episode. An accurate description and careful observation will differentiate it from the sudden bouts of sleep which typify narcolepsy, the flaccid paralysis of cataplexy, the otolith syndrome and labyrinthine vertigo, hysterical seizures, migraine, the sudden falls of myotonia, and other simulating disturbances. But there is even here suggestive evidence that such conditions as narcolepsy and cataplexy have similar funda-

mental mechanisms to those of epilepsy. The term " syncope " or " faint " needs a brief reference. It does not differ fundamentally from epilepsy. It applies to a cerebral anæmia due to a sudden lowering of blood pressure from cardiac or nervous causes which temporarily depresses the nerve cells of the medulla ; it shows itself by pallor and transient loss of consciousness, but it may be accompanied by, and if prolonged is always followed by, epileptic phenomena.

When we turn to a classification of the causes of epilepsy we must bear in mind the general principle earlier enunciated, viz., that any change in the nerve cell—structural or functional—may lower its epileptogenic threshold and excite the abnormal energy discharge which leads to epilepsy. Table II presents an etiological classification based on this principle.

TABLE II.

ETIOLOGICAL CLASSIFICATION OF EPILEPSY.

1. *Structural brain disease*—congenital, traumatic, inflammatory, neoplastic, degenerative, parasitic, etc. (Commonly :—expanding lesions, trauma, degenerations, syphilis—G.P.I.)
2. *Metabolic*— anoxia, asphyxia, hypoglycæmia, alkalosis, water retention, allergy, disturbance of phenylpyruvic acid metabolism, hypercalcæmia
3. *Toxins*—
   (a) infections—*e.g.* pneumonia or pyelitis in children
   (b) exogenous—alcohol, lead, cocaine, camphor, ether, absinthe
   (c) endogenous—uræmia, cholæmia, eclampsia
4. *Circulatory disturbances*—resulting from arteriosclerosis, hypertensive encephalopathy, heart-block (Stokes-Adam syndrome), paroxysmal tachycardias, hyperreflexia of carotid sinus
5. " *Cryptogenic* " (" idiopathic " or " essential ")

Time will not permit a detailed consideration of the differential diagnosis of these causes. The importance of a careful history and a complete physical examination cannot be over-emphasised. In taking the history questions should be directed to possible etiological factors ; a previous head injury, an earlier primary chancre, fits occurring four to five hours after meals, similar attacks in the family, a history of convulsions in childhood ; these and other facts elicited from the history are all significant " pointers." And no system can be overlooked in the physical examination if the cause is to be unmasked. Special methods of investigation will include X-rays of the skull and, where indicated, pneumo-encephalography and cerebral angiography ; examination of the blood and cerebro-spinal fluid—manometry, Wassermann reaction, protein and cell content, Lange's gold curve and other colloidal tests ; and electro-encephalography, though I would remind you that the instrument has significant limitations and we must be wary of the dangers of exploiting this valuable aid to diagnosis. Where specific causes are suspected other tests may be necessary, *e.g.* a glucose tolerance test in possible hypoglycæmia, renal function tests in suspected uræmia, electro-cardiograms in associated disturbances of cardiac rhythm or conduction.

Such investigations will lessen the number of " idiopathic " or " cryptogenic " epileptics, for they often reveal a gross cerebral lesion which is quite adequate to account for the lowered epileptogenic threshold and the consequent attacks. But we remain ignorant of the cause in many epileptics, especially those with a family history, with fits dating from childhood and persisting over many years, and with petit mal attacks either alone or associated with

major attacks. For these the term " cryptogenic " is preferable to " idiopathic " or " essential " epilepsy ; moreover, it is literally a more accurate label.

To the treatment of epilepsy many important contributions have been made in recent years. It is necessary, of course, to deal with the cause when this is known, but it must not be forgotten that removing the cause will not necessarily eliminate the tendency to fits ; for a tumour before its excision may have caused irreparable damage to contiguous brain tissue, a gumma in healing leaves a scar, and a cicatrix cannot be excised without leaving a scar in its place. Thus even where an organic lesion is eliminated, the symptomatic treatment we use in cryptogenic epilepsy may still be needed

There are four major principles governing the medicinal treatment of epilepsy. First, some patients do not benefit from drugs ; if this is revealed after an adequate trial it is both wasteful and harmful to continue them. Secondly, there is no uniform dosage of anti-epileptic drugs ; each patient must be treated as an individual problem, careful records should be kept of dosage and time of administration and of the occurrence of fits and the drugs regulated accordingly. Here the electro-encephalograph occasionally helps but it is not indispensable. Thirdly, anti-epileptic drugs affect the various forms of epilepsy differently, thus the type of fit must be recognised if the greatest benefit is to be secured. Finally, treatment is designed to benefit the whole patient ; if the attacks are controlled but the patient rendered senseless by the drugs there is little merit in the medication.

The drugs of proved value in epilepsy are bromides, phenobarbitone, dilantin (sodium 5.5–diphenylhydantoinate) and its less toxic derivative—mesantoin (3–methyl–5.5–phenylethylhydantoin—Sandoz) and tridione, (3.5. 5–trimethyloxazolidine–2.4–dione—Abbott). The *bromides* are now little used because they are usually less effective than the newer drugs and also because their toxic effects are more marked than is commonly appreciated. Not only do they cause unsightly acne but they depress the patient, slow his mental activity, and often accumulate to produce a toxic psychosis with hallucinations, delirium and even coma. I have seen this condition go unrecognised for long periods. If severe depression and mental slowing are present in an epileptic taking a bromide mixture, it should be stopped and the blood examined for bromides. If these are found in quantities greater than 150 mgm.% another anti-epileptic drug should be substituted for the bromide and to accelerate its excretion 10–15 grm. of sodium chloride given daily in divided doses. Occasionally, however, bromide suits a patient better than other drugs ; when this occurs the blood bromide should be estimated at regular intervals to prevent the development of cumulative effects.

Phenobarbitone or " luminal " is the drug most commonly used in the treatment of epilepsy. It, too, may cause skin rashes of a maculopapular (morbilliform) type and in larger doses it may slow cerebration ; benzedrine or caffeine will often counter this mental dulness without diminishing the anticonvulsive effects of the drug. Doses of $1\frac{1}{2}$ to 2 gr. of luminal daily, suitably spaced, usually suffice but larger doses may be needed. In its soluble form the drug may be given subcutaneously, intramuscularly or intravenously in status epilepticus, though I prefer the newer basal anæsthetics—evipan, avertin, etc.—for this condition. One danger is often overlooked. The more potent anti-epileptic drugs, especially phenobarbitone, must not be suddenly withdrawn for this commonly leads to status epilepticus. On several occasions I have

seen patients, admitted to hospital for the investigation of epilepsy, develop status epilepticus on the second or third day. Enquiry has revealed that these patients were taking luminal until admission to hospital when it was discontinued. Status epilepticus is always a dangerous, and may be a fatal episode, so the warning is necessary.

The anti-convulsant effects of *dilantin* (epanutin) are not accompanied by mental changes or lethargy; toxic effects, however, may occur, especially (1) rashes and occasional fever, (2) ataxia, nystagmus, and ocular palsies, and (3) hyperplasia of the gums with soreness and occasional bleeding. Often after the drug is discontinued for a week or two it can be resumed without recurrence of untoward symptoms. Dilantin is especially useful in grand mal, focal epilepsy, and such psycho-motor disorders as automatism. The dose is 1½ gr. two to four times a day, given with or after meals to avoid gastric irritation. Its derivative, *mesantoin*, less frequently produces toxic symptoms and has in some patients a greater suppressive effect. Dilantin is often usefully combined with phenobarbitone. A careful empirical determination of their joint use in relation to the time of attacks will be well rewarded.

The most recent addition to the therapeutic armamentarium of epilepsy is *tridione* and its special value lies in the suppression of petit mal, myclonic jerks, the akinetic types and psycho-motor attacks. For adults a dose of five grains may be given thrice daily and carefully regulated. Toxic reactions are rare but agranulocytosis and aplastic anæmia have been reported. Regular blood counts should be made to obviate these. Tridione is most helpfully combined with phenobarbitone and dilantin where petit mal and psycho-motor seizures co-exist with grand mal.

Let me reiterate how important it is to individualise in the treatment of the epileptic patient. Only by prolonged observation of the results of treatment and by varying the dosage and the drug used will the maximum benefit be secured.

I cannot deal to-day with other major problems in the management of the epileptic; the avoidance of dangerous occupations; the task of creating confidence in himself so that he faces his misfortune with equanimity; the problems of marriage and the rest. Nor can I touch on the many responsibilities for social medicine which epilepsy calls forth. These are of major importance but time imposes its limitations. I must rest content if in presenting some of the clinical problems I have helped you to clarify your conceptions of epilepsy and have shown by this example that the methods of medicine do not differ from those of natural philosophy and that there is still truth in Galen's maxim that "every physician should be also a philosopher."

An Appreciation

"GIBBS."

GIBBS has gone, and with him a tradition of service in the P.M. Room at Guy's which changed little during his twenty-eight years of service—twenty of which I had the pleasure of experiencing.

Unobtrusive and reserved as Gibbs was, he had great character, sizing up both the new boy and the distinguished visitor with shrewd judgment and unerring accuracy after a few moments trial with his acid test—the necropsy. He was a fine technician himself and had a reputation not only among several thousand of old Guy's men, but among a wide public of circle morticians in the Home Counties, police, in the prison service and at many lesser hospitals to which his "overtime" had taken him. His

attendance at judicial execution autopsies had undoubtedly introduced new order into the somewhat haphazard disposal of the criminal dead.

Patrick Laidlaw was the first of a line of distinguished pathologists who passed through Gibbs' Department—it was referred to as " Gibbs' Department " by physicians and surgeons discussing the prospects at ward rounds—and hundreds of Guy's men, myself included, to whom it fell subsequently to perform an autopsy, owed much to Gibbs' patient training.

He decried the bloody battle, discouraging much expenditure of energy, admiring great delicacy of touch, and the art of knowing just where to put the knife and where to propel it. His face, usually impassive, would draw into a hurt frown if his demonstrator determined to get through that calcified plaque by fair means or foul, but wreath in smiles if a sample of his skill were pointed out to the students.

He was a good judge of the pint, but no lover of the c.c., a man for reasonable but not fussy accuracy, and always at hand to smooth out the troublesome passage of a demonstrator who, in extremis, knew that a stentorian call of GIBB · (no one ever knew or cared whether he had an " s " on his name) would dispose of his difficulties.

Gibbs' resourcefulness at autopsy was legion. He has used the crown of the bowler hat, plaster of Paris, rolls of wool, broom-sticks and other aids to plastic (post-mortem) surgery with original skill after the removal of " exhibits " or specimens, and he loved to tell how he did a splenectomy per vaginam when autopsy was refused.

His favourite performer was, I think, Prof. G. W. de P. Nicholson—" Old Nick " to Gibbs—who could, with consummate skill, dispose of some four to five autopsies in the hour, observing all. Time was a significant factor in Gibbs' ordered life, and he understood those for whom time mattered—though no one, in his view, was too busy to be punctual.

I have suffered a personal loss in the going of Gibbs, near retirement as it may have been, and I and many others will miss his reserved smile and quiet sense of personal service. Guy's has lost a traditional servant.

KEITH SIMPSON.

Correspondence

Ornithological

SIR,—The notes in previous issues of the *Gazette* on the local occurrence in the Borough of that dictatorial bird the Dodont, have been of great interest to Ornithologists. I should like, therefore, to describe a certain habit of a more widely distributed, highly specialised, raptorial bird, the Smooth-tongued Mug-hunter. It is a member of the same genius as that other Mug-hunter, the Cuckoo, and is found all over the country frequenting town and rural areas impartially ; indeed, I remember observing its activities during my days at Guy's, so that I hope this communication may serve as a warning to potential victims as well as a contribution to Ornithology.

The birds natural prey is the Willing Horse, and though by day it seeks others besides those in the medical profession, in its crepuscular flight it hunts especially junior partners and assistants in general practice. After dark, particularly on moonless or foggy nights, it ranges far, seeking a mug who will turn out late at night and visit a case of illness of a week's standing. Its approach is noisy, giving the impression of great urgency often deceiving the inexperienced, but if the victim makes brief enquiry into the circumstances and firmly refuses to be beguiled, the bird flies off with a low muttering call, in order to try the same tactics on the next Willing Horse.

I hope that future editions of the " Handbook of British Birds " will contain a formal description of the Smooth-tongued Mug-hunter, and I will give no further details here. I hope that greater interest will be shown in an inadequately studied species.

I am, etc.,

JUNIOR PARTNER.

Physicillogical

SIR,—A former Guy's nurse, now married to a Kenya farmer, runs a dispensary for local Africans at her farm. The following letter which was received from the local African school master, when refering patients to her, may be of interest :—

The Kikuyu Independent School,
Nania P.O.,
South Kinangop Dairy.

"To The Mistress L——,

With humility to inform you that those three boys are pupils at the above-mentioned school. They now need to be given the medicine illogically (? empirically) to their illness. I hope them to give you their illustrations of their diseases accordingly but myself I can't recognise which kind of disease it is. I should be much obliged if you will treat them recently and come to school imminent.

Yours obediently servant schools master,
B. KAMAU."

I am, etc.,
Guy's Hospital. "PLUS CA CHANGE."

Sport

RUGBY FOOTBALL

GUY'S *v.* BIRKENHEAD PARK

at Birkenhead Park. Won 16—8.
8th November, 1947.

The game was played on a soft ground for almost the first time this season, and despite a heavy wind was very open and fast. Taking some little time to setde down after six hours travelling, the Hospital were on the defensive for some 15 minutes. During this time the Park wing three-quarter made a very clever interception to score far out, giving them a three point lead. The Hospital side however rapidly pulled together and shortly before half time Raderman scored a clever try which D. Le Clus converted.

After the interval Guy's began to take command and with Keeling hooking from three-quarters of the scrums and the wing forwards excellent spoiling tactics we were rarely on the defensive. Brunow played his usual excellent game, his touch kicking being immaculate in length and direction. It was from three break-throughs by him that tries were scored by D. Cottier, F. Retief, and M. Gray.

GUY'S *v.* CAMBRIDGE UNIVERSITY

at H.O.P. Won 15—12.
12th November, 1947.

The visit of Cambridge University was eagerly awaited by Guy's enthusiasts who were rewarded by one of the most exciting and entertaining games for a long time. The University had only three changes from the side narrowly beaten by the Wallabies, but these tended to strengthen rather than weaken the side.

D. Le Clus took the place of T. L. T. Lewis who was playing for Middlesex in the County Championship, and gave a sound exhibition of full-back play at its best. Guy's took advantage of a strong wind and immediately set up a full-blooded attack with forwards particularly good in the loose rushes and the backs handling nicely. The University found it extremely difficult to get away from their own half, and eventually F. Le Clus intercepted a pass and running up to the full-back sent in D. Cottier for an excellent try which D. Le Clus converted.

Guy's maintained the pressure with F. Le Clus, the shining light of an inspired back division, and D. Le Clus kicking a good length and positioning himself well. Our forwards carried out a dashing run and packing solidly around a loose scrum, crossed the line in a heap for a try awarded to B. Eksteen and again D. Le Clus converted. This was the score at half-time which literally took the breath away from the onlookers.

Against the wind Guy's continued their ascendency, but suffered misfortune when N. Malyon was injured but returned later obviously a cripple. The University started a three-quarter movement just inside their own half when P. Rademan brought off a magnificent tackle on the Cambridge centre, and from the loose F. Le Clus picked up the ball and ran in for an exciting try that D. Le Clus converted.

Cambridge University were showing signs of anxiety. They had been completely outhooked and our forwards had dominated the opposing pack in all phases of forward play. At the same time, they tackled promptly and hard, giving the University backs little chance of breaking through.

All the Cambridge points came in the last 11 minutes after D. Le Clus had brought off a great tackle to prevent H. M. Kimberley crossing. First of all the light blues were awarded a penalty which R. H. Lloyd Davies just missed with a long kick, and was followed by a cross-kick from the Cambridge left that enabled W. B. Holmes to cross in the corner for R. H. Lloyd Davies to convert near the touch-line. Maintaining their improved play amidst tremendous excitement from the crowd Cambridge were awarded a penalty kick which R. H. Lloyd Davies successfully negotiated, and in the closing minutes A. F. Dorward, the University scrum-half, dropped a goal.

Nobody can deny that this performance by the Hospital stamped them as a good all-round team, fully justifying all the high hopes of the Captain, H. L. Brunow, who, although unable to play in the match, was a great inspiration from the touch-line and at half-time.

Team : D. Le Clus, D. F. Cottier, G. P. Billingham, F. Le Clus, M. J. Gray, G. Baker, P. D. V. Harrett, A. B. Lee, J. H. Keeling, A. N. Du Plessis, B. W. Cole, N. Malyon, B. Ecksteen, M. Hatton (Captain), P. Rademan

Cambridge University : R. H. Lloyd Davies, W. B. Holmes, K. A. N. Spray, H. M. Kimberley, R. W. Griffiths, W. M. White, A. F. Dorward, P. J. de A. Moore, A. P. Henderson, T. S. MacRoberts, S. V. Perry, J. Gwilliam, W. G. Davies, E. Bole (Captain), H. H. Mills.

GUY'S *v.* ROSSLYN PARK

at H.O.P. Won 5—3.
15th November, 1947.

Although Guy's emerged successfully from this match by defeating Rosslyn Park by a goal to a penalty goal, there were many among the small number of spectators who wondered audibly what had gone wrong with the team. Since the Cambridge match the team has shown a gradual decline, but it is noticeable that opposing teams are mindful of Guy's run of successes and use every effort to bring about our defeat. This to us is a great compliment and all to the good of the side who are called upon now to fight every inch of the way.

E. Kverndal kicked an early penalty goal for the Park and led by this at half-time, but G. Baker broke through and gave M. Hatton a great chance to cross, but he was collared a yard from the line. Subsequently, from the tackle an infringement caused the referee to award a penalty try, although G. Baker actually touched down. D. Le Clus converted.

Team: D. Le Clus, D. F. Cottier, F. De Clus, F. Retief, M. J. Gray, G. Baker, P. D. V. Harrett, W. Wolfsohn, J. Keeling, A. Du Plessis, K. Simpson, B. W. Cole, B. Eksteen, M. Hatton, P. Rademan.

GUY'S *v.* UNIVERSITY COLLEGE, DUBLIN

at H.O.P. Won 3—0.
17th November, 1947.

This was the Hospital's fourth game within nine days, and at no time did they play with the confidence and vigour which we were getting accustomed to see. The pack were not up to their best but, nevertheless, gave a smart Dublin pack a hard tussle. Outside, however, the movements were invariably spoiled by faulty handling or hard, first-time tackling by the very disruptive Irish back row forwards.

The only score in the match came after ten minutes of the second half, when J. D. V. Harrett danced nimbly round the blind side of the scrum to catch the whole of the Dublin defence going the wrong way. The kick was missed—Guy's held on to the end to achieve their 6th successive victory, a record only held by one other club in London; more cohesion is going to be needed however if this record is to be improved upon.

GUY'S *v.* METROPOLITAN POLICE

at H.O.P. Drawn 3—3.
22nd November, 1947.

In view of the Hospital's past performances and those of the Police, it came as a big surprise to find our visitors holding us to a draw with both sides scoring a try.

With H. Brunow still away through injury, an experiment was made by playing F. Le Clus at outside-half and D. F. Cottier in the centre. Never at any time during the game did the new formation show any signs of cohesion, or even possibilities of developing into a scoring machine. The Police appeared to detect this weakness and promptly destroyed any attempt of our forwards to break away to the advantage of the backs.

The Hospital team showed signs of staleness and excuses may be found for them on this account owing to the strength of the hard fixtures compelling them to play four times in ten days.

D. Le Clus was an early casualty, but M. Hatton played very well on the wing, taking the place of M. Gray who went to full-back.

The play was mostly scrappy and good movements strictly limited. The Police took the lead in a peculiar manner, when P. Bennett sliced the ball from a penalty kick across to the winger Ezckiel who went over for a try, but Guy's drew level with a try by F. Retief following good work by the forwards.

The Police also lost a player, D. G. Davies with a cut eye early in the second half, and although having the advantage of the wind failed to score again, but the Hospital had many anxious moments.

GUY'S *v.* COVENTRY

at H.O.P. Lost 3—6.
23rd November, 1947.

Coventry paid the Hospital a great compliment by sending their strongest side to H.O.P., and were worthy victors by a try and a penalty goal to a penalty goal. The Hospital although playing better than in recent games are at the moment a negative combination. Forward they are playing well and were more than a match for the heavier Coventry pack. Behind the scrum, however, they are ineffective, and if this side is to develop into a real cup winning side they must adopt a more attacking style of play.

Coventry kicked off with the wind and were soon inside the Guy's 25. Grand disruptive play by wing forwards easily broke up any attacks and play remained scrappy for 15 minutes. From a line out Adkins, the Coventry back row forward, made a grand interception and running his fastest passed inside on reaching the full back for a try by Draper near the posts. Shortly afterwards, Wright landed a penalty goal and at half-time Coventry were 6 points up.

After the interval Guy's forwards took control and completely out-played their opponents. Points however eluded them until Lewis landed a long penalty goal mid-way through the half. After this, with Coventry now two men short, the Hospital should have pressed home their advantage. Gray and Cottier made gallant runs on the wings, but were never fed well enough to be match winners, and no side came without further score.

G. P. Billingham, playing at stand-off half in place of H. Brunow who is still injured, was adequate but the backs seem to be in need of Brunow's stabilising influence.

T. L. T. Lewis and J. H. Keeling have been selected to play, at full-back and hooker respectively for the Possibles in the first English Rugger Trial on December 6th.

HOCKEY

GUY'S *v.* SITTINGBOURNE

at Sittingbourne. Won 6—0.
22nd November, 1947.

In the early minutes of the game, Earl, the Hospital's centre forward, broke through and scored the first goal; but from then until half-time there was no further score. Play was never of a very high standard, and Guy's suffered from the fact that one or more of their forwards was off side with such frequency that many movements came to nothing.

In the second half the forwards were much improved, goals coming from Kelsey Fry (1), Earl (1), and Blake (2). There were several good passing movements, notably one from the right half, at the throw in, to the inside right, and then across the field to the inside left, who scored.

The defence was never severely tested, but the change of Murray from centre half to right back proved a success.

Team: F. Walker, G. H. Danford, E. A. Murray (Captain), J. B. Harris, C. H. Opie, R. A. Keable-Elliott, D. V. Duckworth, D. G. Blake, S. S. R. Earl, I. Kelsey Fry, R. F. Hodson.

GUY'S *v.* BIRMINGHAM UNIVERSITY

at Birmingham. Lost 2—4.
25th November, 1947.

An enjoyable day, a record broken, a lesson learnt. Birmingham University, on their own ground deserved their victory. The game was won in the first quarter of an hour in which Birmingham scored two goals. From then onwards, Birmingham proved themselves the best team that Guy's has met this season, and put into practice some of the principles of good hockey that Guy's have not yet mastered, probably through lack of stronger opponents. At half time the score stood at 3—2, Birmingham scoring their third before Hodson and Kelsey Fry scored Guy's two goals. In an even second half Birmingham scored their fourth goal.

The worth of an unbeaten record for ten games is to be measured only by the consideration of our opponents, that we held Birmingham to such a score is a worthy achievement, Guy's played their best game of the season to deserve it. Mention must be made of G. H. Danford who contributed most to the standard of Guy's play, and as secretary was responsible for the whole journey being made in armchair comfort.

We thank Birmingham for showing us how to play hockey from the first whistle, how to pass and how to follow up a shot into goal; we hope that when we meet them next we'll beat them at their own game—good hockey.

Team: F. H. Walker, G. H. Danford, E. A. Murray (Captain), C. H. Opie, W. Vans Agnew, R. A. Keable-Elliott, D. V. Duckworth, D. Blake, S. S. R. Earl, I. Kelsey Fry, R. F. Hodson.

E.A.M.

Hospital Information, etc.

NOTICES

Applications are invited from qualified Medical Practitioners for the post of Resident Medical Officer to Nuffield House. This post is graded B.2 and carries a salary of £300 to £350 per annum, according to experience, rising by £50 per annum on the completion of six months' service to £400 per annum, with full residential emoluments. This appointment will be for a period of six months in the first instance but will be extended for a suitable applicant.

Applications should be sent to the Secretary of Nuffield House, Counting House, Guy's Hospital, S.E.1, not later than 16th December, 1947, and the selected applicant will be expected to take up his duties on 17th January, 1948.

LANDON TEA FUND.

This Fund was inaugurated in 1897 by the late Dr. T. W. Landon, who, when a student, raised subscriptions for the first tea, given in the Out-Patient Department on Christmas Day to 600 children between the ages of 6 and 11 years. A tea has been given each year since that day, except for the war years, and in addition the children have a Christmas tree, entertainments, and presents to take away with them. It would be impossible to find anywhere in London a happier or more delightfully noisy party, and any members of the Staff who have not attended this function are invited to do so. It will be held in the Out-Patient Department on Christmas Eve this year, at 4 p.m.

The Fund is badly in need of financial support, its income from invested funds is only £14 per annum, whereas the expenditure this year will amount to nearly £100 to entertain 300 children.

Each child costs about 6*s.* 8*d.* to entertain and you are invited to provide for one or more guests at the party. Please send your subscription to Sister Bird, Out-Patient Department, Guy's Hospital.

RECENT DANCES.

Both the Students' Union and the Dental Society have recently held highly successful dances. 300 couples were at the Students' Union "Royal Wedding Dance" at St. Pancras Town Hall, and 250 at the Dental Society's Annual Dance at the Grosvenor House. The next Students' Union Dance will be at the Porchester Hall, Paddington, on February 11th.

MISSING.

The March Volume of the Annals of Surgery, which is now out of print, is missing from the Surgical Library. Will the borrower please return this number as soon as possible, otherwise the volume will have to be bound incomplete. Users of this Library are reminded that books and publications must not be removed from the Surgeon's Room, where they may be studied at any time before 10 a.m. and after 6 p.m.

PASS LIST

UNIVERSITY OF LONDON.
THIRD (M.B., B.S.) EXAMINATION FOR MEDICAL DEGREES.
October, 1947.

Pass.

S. Adler	K. E. Hodge
G. C. Ambrise	A. J. I. Kelynack
G. J. Amiel	J. V. Kilby
A. W. Banks	E. L. W. Leiser
J. H. Baylis	J. E. Mandel
D. A. G. Brown	B. C. Morgan
R. H. Browning	J. B. Morrison
R. A. Bush	F. J. Napier
E. G. Cook	J. A. R. Parker
D. H. Crook	W. A. Porter
W. M. Dixon	R. L. Ray
G. W. Downes	E. Robinson
L. R. L. Edwards	D. A. Skan
D. H. Forsdick	G. F. Vaughan
R. C. Hallam	P. J. F. Walsh
S. J. Harris	J. L. Warren
J. L. Hayward	R. D. Willcock
A. J. Heber	J. R. D. Williams
A. W. Hind	P. Wilson

CHANGES OF ADDRESS

David Erskine, M.D., 62, Queen Anne Street, London, W.1 (Tel. Welbeck 8626), and (from February 2nd) 146, London Road, Gloucester. (Tel. Glos 2462.)

A. W. Fooks, Sonning Lodge, 36, Eastwood Lane, Westcliff-on-Sea, Essex. (Tel. Southend 44611.)

A. D. Marston, M.R.C.S., D.A., 119, Montagu Mansions, W.1. (Tel. Welbeck 6170.)

D. J. Tibbs, M.C., M.B., B.S., 53, Lee Road, Blackheath, S.E.23. (Tel. Lee Green 1972).

David Wheatley, M.B., B.Ch., 270, Staines Road, Twickenham. (Tel. Popesgrove 2722.)

BIRTHS

HANCOCK.—On November 23rd, 1947, at Warleigh Nursing Home, Wimbledon, to Betty (née Christopherson), wife of J. Gordon Hancock—a daughter.

THOMAS.—On November 8th, 1947, at Nuffield House, to Anne (née Doogan), wife of Dr. Gerald Thomas—a son (Richard Trevor).

MARRIAGE

WOLFSON—ESCHELBACHER.—On October 29th, 1947, in London, Leslie Joseph Wolfson, M.B., to Nancy Eschelbacher, S.R.N., 30, Salisbury Road, Birmingham, 13.

DEATHS

KNOX-DAVIES.—On October 24th, 1947, Ed. Aubrey C. Knox-Davies, L.D.S., R.C.S., of Sea Point, Cape Town, S.A.

EDS. { H.A.R. / R.A.K-E.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

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PASSIM

THE British are a peculiar race in many respects, but not the least of their eccentricities is their passionate devotion for tradition and ceremonial. At certain times and on certain occasions functions of one kind or another become indispensable. The boat race, test matches, and the changing of the guard are three common examples, but there are countless more. Christmas, although a Christian festival the world over, well illustrates this love of tradition. Ideally it should be spent at home, preferably when there are several feet of snow outside, and at least one large fire within. It is the time for deep leather armchairs, for glasses of port, for yule logs and Christmas trees, and all the other countless things, many edible, which are so essential for the full enjoyment of December 25th.

But among the many activities of Christmas Day, there is one period when all is rest and quiet. It is that almost sacred time that comes immediatly after a true Christmas lunch, and immediately before His Majesty's speech. It is then, when all is peace and solitude, that the thoughts of many old Guy's men must turn to the neighbourhood of the Borough Hospitals, and whilst they dream and meditate on the days when they were at Guy's, they must surely spare a thought for the Guy's of to-day, and wonder if all goes well with their hospital.

A Christmas spent at Guy's is a never to be forgotten experience. The hospital itself is in the middle of the "Dicken's country," and a true Pickwickian atmosphere pervades the Borough during this festive season. Wherever one goes, be it to the old world simplicity of the George, or to any of the gaily decorated wards, an overwhelming wave of goodwill and jocularity will greet you. The staff, the nurses and the patients are all determined to enjoy themselves, and they all invariably succeed.

There are several aspects of Christmas that are peculiar to Guy's. To many the first to come to mind is probably the Niggers. They, alas, are no more, and there is a generation in the hospital now to whom even their name is unfamiliar. They are the victims of voluntary euthanasia, and to resurrect them now would be to resurrect a ghost. But apart from the Niggers, and the residents' play which was performed earlier in the year, Christmas here remains virtually the same as it always has been. The out-patient's hall, which was once somewhat unkindly, but not inaptly, likened to a palatial public lavatory, becomes almost cosy when festooned with decorations and bunting. The colonnade, which seems somehow to reflect the shadows of the nineteenth century, rather than those of the twentieth, echoes to the sound of Christmas music. The hospital is ablaze with lights, and lanterns and Christmas trees can be seen silhouetted against the windows of Hunt's House. The bells of Southwark Cathedral, silent throughout the war years, are ringing out again, and as their chimes are carried across London Bridge they carry the same message to all Guy's men the world over—"Good Luck, and a Merry Christmas to you all."

Our Dental Correspondent writes :—

WE offer our congratulations to the following Guy's men who are among the first to be elected Fellows in Dental Surgery of the Royal College of Surgeons of England :—Mr. F. S. Warner, Sub-Dean of the Dental School; Professor R. V. Bradlaw, Dean of the Sutherland Dental School, Newcastle-upon-Tyne; Mr. F. N. Doubleday and Colonel E. B. Dowsett, Consulting Dental Surgeons to Guy's Hospital; Mr. W. Kelsey Fry, Dental Surgeon to the Hospital, and Mr. A. E. Rowlett, a past-president of the B.D.A.

Readers may be interested to hear of changes which are taking place in the Dental Department. The Pre-Clinical Department is now on the second floor of the old Pathological Block. The Old Pathological Theatre has been metamorphosed by the

Works Department into a Dental Lecture Theatre. The old Pre-Clinical Department on the ground floor of the Dental School is to be the Department of Preventive Dentistry, and an annexe to the Dental School will provide a new Waiting Room and the Office of the Administrative Dental Officer.

IT is with regret that we bid farewell to David Erskine. His has been a more familiar face about the Hospital than most. We learn that after a holiday in South Africa he is taking up the post of Area Dermatologist to North Gloucestershire. We wish him good biltong and good luck.

A Ground plan of the proposed "New Guy's" will be found published in the December number of *The Post-Graduate Medical Journal*. We understand that the Architect's Plan is at present in the hands of, and under consideration by, the L.C.C. who have sent representatives down to see the proposed site.

THE final delightful etching by Mr. Hanslip Fletcher appears in this issue. Copies may be obtained of all three etchings: The Gates, The Park, and The Medical School (size 8 in. by 11 in.) at 1*s*. each, post 6*d*. extra.

Guy's Diary

DECEMBER—JANUARY

ACADEMIC

23rd. 13.00. Clinical Lecture. Mr. Kilpatrick. "Tuberculosis of the Kidney."
30th. 13.00. Clinical Lecture. Mr. Blackburn. "Acute Intestinal Obstruction."
1st. 13.00. Clinical Lecture. Mr. Wass. "Diarrhœa."
2nd 13.00. Clinical Lecture. Dr. Hardwick. "Gout."

SPORT and SOCIAL

20th. Rugby XV. *v.* Moseley (Moseley).
Hockey XI. *v.* West Herts (Home).
20th. 16.30. Physiological Society. Paper, "Traumatic Shock." Mr. K. Cooper. (Tea at 16.00).
22nd 18.00. Carol Singing in Wards by Southwark Cathedral Choir.
24th. 26.00. Landon Tea Party.
25th. *On which day we wish you a Merry Christmas.*
27th. Rugby XV. *v.* Old Millhillians (Home).
29th. 21.30. Nursing Staff Dance.
1st. *On which day we wish you a Happy and Prosperous New Year.*
2nd Aft. and Eve. Rifle Club. Monthly Spoon Comp.
3rd. Rugby XV. *v.* O.M.T's. (Home).
Hockey XI. *v.* Bank of England (Home).

The Future of Our Nurses

THE WORKING PARTY'S REPORT.

By H. ST. H. VERTUE.

BY the kindness of our Matron I received a book in pink paper covers, which bears the title "Report of the Working Party on the Recruitment and Training of Nurses." With a perfectly innocent intention she slipped in also a little document of her own, which was so much more to my taste than the other, that when I met her next I had to admit that I had absorbed the former and rejected the latter and was not yet able to make any comments on it. The result is that the views I express are entirely my own.

The Report begins, "We were appointed as a Working Party, with a Steering Committee, to review the position of the nursing profession." It is a charming picture, is it not? It recalls one of those old-fashioned, roomy skiffs, in which we spent so many happy hours in by-gone days, the men doing all the work and a little bevy of girls propped up on cushions in the stern. But whereas *our* object was no more than to find a good spot upon an ait, there to discuss cold fowl and claret-cup, *theirs* is of a more earnest though not less enjoyable kind: they are going to look at the nurses and see what their position is. Or perhaps we are meant to imagine but a pair of them, like James Thomson and "the little straw hat with the streaming blue ribbons."

I love all hardy exercise
That makes one strain and quiver;
And best of all I love and prize
This boating on our river.
I to row and you to steer,
Gay shall be Life's trip, my dear:
You to steer and I to row,
All is bright where'er we go.

Girls look their best in these circumstances, but, as every old hand knows, they are apt to become dreamy and inattentive: so does the Steering Party. As early as para. 3 they have to be "kept in touch with the progress," and in the very same paragraph we discover that they are so utterly bemused that they fancy they are still in the train, proceeding along lines. A painful scene of ejection probably occurred, but we are spared all details. We hear no more of them and the Working Party manages the boat alone, mindful perhaps of the time-honoured precept, "Bow steers." Let us see how they get on.

Their next sentence is, "In a letter dated 21st January, 1946, we were advised that the impending establishment of a National Health Service would undoubtedly increase the demand for more nurses even above the present level, and thus rendered a comprehensive review of the whole nursing service and its problems of first importance." The Party is going past the gas-works, or so I surmise from the ugliness of the sentence, and one of them has caught a crab. For they speak complacently of reviewing the whole nursing service: there is no such thing: there are simply women who nurse because they wish to, and a service is a pure fiction. This palpable error puts us at once on our guard, for we are warned thereby that the Party means to take the living woman and make her fit into some conception of its own.

The Report goes on, "It was suggested that we should survey the whole field of recruitment and training of nurses of all types. . . ." Nurses are not trained in a field, nor are recruits to be found there, nor are nurses recruits, nor are they to be classified in types.

One pauses here, for the comedy of the thing has begun to fail. Between the gentle ladies whom we know and honour, who spend their days of their own free will in doing deeds of kindness to those that sorely need them, each and all with her portion of the divine spirit, and the stupid and inhuman view that this Report has already revealed in half a page there can be no reconciliation. Where one is, the other cannot be. Of the framers of this document we know even now that they do not think clearly, do not write well, do not see what they are supposed to be looking at and are adherents of the common heresy of our time, that which propounds that human beings are a mass of material. Any practised reader would toss the book aside as valueless, but there are urgent reasons for not doing so. Governments, for some reason unknown to me, are apt to believe that reports of committees such as this are inspired, adopt them and enforce their recommendations. There are reasons that will soon appear for supposing that the present Government would be especially impressed with this report. For all we know then this thing in the future may be fastened round the necks of our nurses like a dead albatross and hang there.

But the Working Party has now reached the nurses and is going to tell us of its "method of approach." There was once a great Englishman, by name, Charles Dickens, who created a character out of just such a one as that which appears in this Report and called him Gradgrind. Hearken to the voice of the new Gradgrind. "We use the term scientific advisedly, in the sense of endeavouring to achieve the utmost objectivity and precision within the limits of our competence and the time at our disposal, and to reach conclusions not resting solely on opinion but verifiable by reference to facts. Our object has been, not to form impressions, but to discover, if we can, the facts and let the facts speak for themselves." There it is for all the world to hear, the authentic note, "Hard Times," chapter one, page one; only the earlier Gradgrind could and did use forcible plain English and the Working Party does not. "Thomas Gradgrind, sir. A man of realities. A man of facts and calculations. A man who proceeds upon the principle that two and two are four and nothing over, and who is not to be talked into allowing for anything else." Mr. Gradgrind, native of Coketown, would be called to-day "an industrialist." You might as well offer a violincello to that orang-utang of Balzac's and expect him to discourse sweet music as present an industrialist with a nurse and ask for good advice. It matters not that the ladies and gentlemen of the Party in their private lives are not engaged in industry and may be quite different: they

live in an industrial age and they have caught the industrial outlook. For the present purpose they are Gradgrind.

Forthwith Gradgrind sets out in earnest to gather facts. He wants to know how many nurses there are, what their " pre-nursing occupation " is, what their fathers' occupation is, what their " educational level " is, what their age is, and so many other things that I cannot enumerate them. He compiles many tables and, of course, draws graphs. It now strikes him that a nurse must have some intelligence and he expresses the bright thought thus, " The level of intelligence or educability of the potential nurse is of decisive importance, both as regards her training and professional practice." What the level of an intelligence may be I do not know, but Gradgrind would not be Gradgrind if he did not try to turn it into tables and diagrams. It is not at all surprising that he should go to the War Office to find out how to do this, because we know that he looks upon nursing as a " force " or a " service " and those who take it up as " recruits." But he has another test called " Progressive Matrices, 20-minute version." A modest knowledge of the Latin tongue tells me that a matrix is a female animal kept for breeding and I wonder how the word came to be used in this connection. My curiosity is not diminished when I learn that in fifteen years a nurse loses four matrix marks. The conclusions reached by Gradgrind after so much labour constitute a stunning surprise. Nurses' intelligences vary, or as he puts it in his winning way, they are not a " homogeneous group." As a whole they are rather above the average. The voluntary hospitals come off best, the municipal next, and the fever hospitals, sanatoria and mental hospitals worst. There now, it was quite beyond your power to know all that. Gradgrind wants to subject all nurses to his tests and hopes by this means to diminish " wastage.'

Whenever I look at that handsome assemblage, a room full of nurses, I think gratefully of the failures who drop out and never finish their training. Without this beneficial process of Natural Selection our nursing profession would not be nearly so fine as it is ; but Gradgrind sees it all quite differently. So long as the coal is hewn, what matter *who hews it ?' Besides the coal does not feel. So to Gradgrind's mind the nurse* who lays down her sponge and towel and walks away from the bedside is just like the miner who puts down his pick and leaves the coal-face ; and accordingly he speaks of a " wastage " of nurses, as he might of miners or hands in a factory. Truth to tell there are hospitals in which this healthy process of elimination of the unfit has passed far beyond the bounds of what is salutary and Gradgrind is quite justifiably perplexed and disturbed. He seems however to be under the delusion (para. 92) that between those who leave and those who stay there is not much difference ; but we who work in hospitals know that it is the least suitable who are shed most easily and the women of best character who remain to the end. In order to account for the excessive loss Gradgrind's zeal leads him into a perfect orgy of facts and figures, at the end of which he comes to the obvious conclusion : that there are some hospitals in which the discipline is strict and old-fashioned, the sisters sour and liberty insufficient. He does not mention the possibility that there may be too many girls to-day who cannot take a spell of discipline at all, nor that some of them may not have the guts of their mothers. Besides this, Gradgrind, accustomed to regard man in the mass, does not discriminate between good and bad hospitals. He has amassed a lot of figures and made a complicated analysis, but he has not enough imagination to discern the individual behind it all. " The longer one studies life and literature, the more strongly one feels that behind everything that is wonderful stands the individual." (*Wilde.*)

Gradgrind has now finished his investigation and is about to pronounce his remedy. " A singularly consistent investigation you have made, my dear Watson. I cannot recall at the moment any possible blunder which you have omitted." Holmes, however, was exaggerating. Let us not forget either that Gradgrind is full of good intentions and does not mean to be unkind, but just has a mind like Chalgrove Field, dull and perfectly flat. He boasts that his approach is scientific : whether it be so or not, it is at any rate not philosophic. A philosopher tries to persuade men to be good by teaching them how to be wise, but Gradgrind disdains the attempt to make them virtuous. " It is no use appealing to them," he says ; so he proposes instead a beneficent tyranny. *Here we see in emblem the history of the last hundred years, the cynical disbelief in* human nature, the decay of liberty and the unwholesome overgrowth of rule and regulation. Here lies the root of the listlessness and sense of frustration that beset us. We know now what it is to live in an ant-hill. No wonder the Report of the Working Party is generally disliked, even by those who cannot put into words what it is that affects them disagreeably · What Gradgrind wants to do is to alter the " structure " of the Nursing Profession. He sees everything materially.

To begin with he notes that nurses do a good many things over and over again during their training as well as afterwards, and he thinks that in the former case at least this must be a waste of time. He enters into elaborate calculations of how many hours could be saved by abolishing the repetition and concludes that it is two thousand five hundred. He requires two thousand two hundred hours to teach "basic nursing skills" (you would not be for long with Gradgrind without hearing the word basic), and triumphantly concludes that a course of two years would suffice for all nursing fields, eighteen months being occupied by a training in common content and six in a chosen field. Poor Gradgrind. He betrays a wistful longing for fields. After all there is something missing in his life for there are no fields in Coketown. To arrive at these figures he undertakes what he calls a "job analysis." Now a job, I must remind you, is a piece of work undertaken for hire, and if there is one thing in the world that nursing is *not* it is a job. A job analysis therefore applied to nursing is an utterly useless thing and no conclusion based on it is of any value. No one conversant with nurses and nursing would suppose that a nurse could be trained in two years, and no nurse that I have asked—and I have asked a good many—believes that it could be done or should be attempted.

Nursing being what it is, a sublimation of the maternal faculty, the repetitive tasks, the washing, feeding, bed-making, getting meals, the derided pillow-smoothing, etc., are the core of nursing, for they are just what a mother does for a child. Patience is required, but patience is the quality brought forth. Gradgrind would not have the subtlety to see this; but in fact no good nurse would suppose that she ought to be relieved of them or that any one else could do them as well as herself. Not that nurses do not get put upon at times, especially when the daily woman walks out, but the immorality of the proletariat is quite a separate study. At Orpington we have instituted ward orderlies, personable young women in neat uniforms, who have done a lot to help relieve the nurses in this matter.

Gradgrind is insistent that a nurse should have the status of a student, but he does not approve of her being an undergraduate. At Universities they teach wisdom and form character, but all that he requires for her is a training: in fact he refers to her more than once by the extraordinarily uncouth appellative of trainee. While she is being trained she will not be nursing the sick; all hospitals, therefore, where this training goes on, will have to keep a permanent staff of trained nurses to do the work. Who are they to be? The Report here creates another want to satisfy a demand. To do all the hard work, while the students like young cuckoos are having the "basic skills" crammed down their throats, would not be an attractive occupation. Meantime, as the students do nothing for the hospital, they will not be paid by it and naturally they ought to pay for themselves. But Gradgrind has the effrontery to assert that the taxpayer must pay for their training and support. This kind of generosity with other people's money is far too common. I should uphold the principle, no work, no pay. Nothing has been earned in this instance and the contemplated "grant" is only a bribe.

The earlier Gradgrind was interested in turning out schoolmasters, "in the same factory, on the same principles, like so many pianoforte legs." The name of his sample product was Mr. M' Choakumchild. The later Gradgrind's factory is called "The Nurse Training Unit"—if he can find an ugly and uninviting name for a thing, be sure he will—and there are to be Regional Nurse Training Boards, Advisory Centres, Standing Advisory Committees, Directors, an Adviser on Nursing Education, and a Chief Nursing Officer. The wheels whir in the Gradgrind factories through an atmosphere murky with integrations, organisations, liasons, mobilities and entities. The material suitable for the works is chosen by officials: Personnel Selection Officers they are to be called. Lest any nurse be denied "equivalent status" the hospitals will no longer engage and train their own nurses. No more Guy's. No more Thomas's. No more Barts. For these old liberty-loving institutions would interfere with the uniformity. No matter if it is such names as these that draw more women into nursing than any others do. What is there to tempt a woman of sensibility to enter this new flat, official-ridden world? "In many cases the profession of nursing is best undertaken by women who are not too highly cultivated, and whose position is below that of the supposed lady." (Stories from the Diary of a Doctor, 1894.) Persevere, Gradgrind, and we shall be back where we started.

All the same there is a hint that we might take from him just here. Our nurses should receive a wider training, in fevers, in tuberculosis, in chronic illness, and in preventive medicine; but it should be carried out within our own walls, or, as I maintain contrary to current opinion, in colonies planted out in healthier surroundings.

It is now my melancholy duty to suggest that Gradgrind's reason began to totter before he had finished his labours, or, to put it another way, the wheels inside his head

were revolving altogether too furiously. His belief was that most of the ills of nursing are due to the Wicked Sisters, especially ward sisters, who are unsympathetic to students and encourage discontent. In my youth, it is true, there were some unpleasant females among them, to work under whom was most trying to a nurse. Are there any now? Discreetly I made enquiries among a few nurses whom I knew I could trust: the answer was, "There is nothing wrong with them." However, perhaps such sisters survive elsewhere,

Old sisters of a day gone by,
Gray nurses, loving nothing new,

as Tennyson says. It is for matrons and hospital boards to eschew this evil and choose for their sisters women of high character; but knowing Gradgrind by now you may be sure that he would be incapable of such a simple procedure himself and would not comprehend its possibility. I fear there is no doubt this time that his passion for mechanical complexity has got the better of him. He proposes to choose a Sister thus—or, if you prefer his method of speech, "The entire procedure involves the following items":

(i) Biographical and personal questionnaire, including a psychiatric "screening" device.
(ii) Two tests of intelligence (verbal and non-verbal).
(iii) Group discussion.
(iv) Test of skill as instructor.
(v) Written views on questions of nursing life and discipline.
(vi) Assigned tasks of Nursing responsibility.
(vii) Sociometric and projective devises.

Poor, poor Gradgrind. With feelings mingled of relief and compassion I leave him emitting this dismal babble and take up the book I had put down when he interrupted me.

"Semper ego auditor tantum nunquamne reponam?" is the poet's opening shot. My sentiments exactly. But it was not just to give vent to them that I took up my pen.

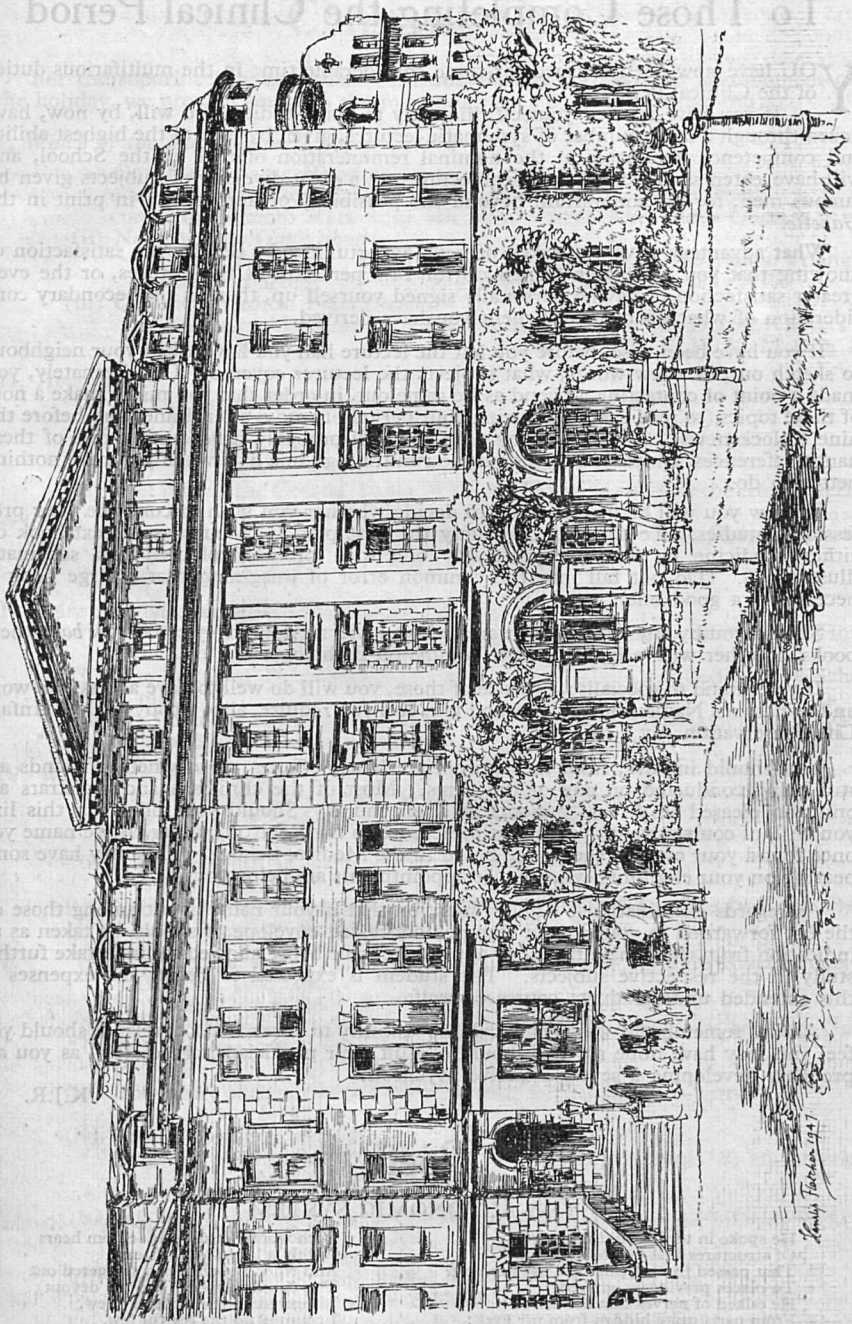
This Report that I have been reviewing shows the outlook of an Industrialist, one too who is much influenced in his ideas by military methods. It so happens that the present Government is one that was put into power and is kept in power largely by industrial workers, and, as one or two of its members have very decently explained, they are its chief or even its sole interest. It knows much of industry, it knows much of warfare, it may find this Report entirely harmonious with itself and it may not be in the least aware of its preposterous nature. Therefore the Report is a real menace. That the quality of nursing would fall if it was adopted seems certain, that even the quantity which the Working Party sets out to secure would be obtained seems doubtful. As a fine, and lofty calling nursing would in all probability be ruined. Do nurses understand all the consequences and implications of the Report? Do nurses retain their critical faculties well, or are they at all readily beglamoured with a few fine words about progress and social service or bemused by Gradgrind's facts and figures? As a general rule nurses are not eloquent about themselves and, with exceptions duly noted, it is often the failures who are vocal, or even vociferous. A few words on their behalf may have their use. As for ourselves, it is very much our concern. Rob us of the fine flower of the best nursing and our efficiency will fall to an unspecifiable but to a great extent.

To turn away from Gradgrind's chimerical world and join hands with the living woman over the bedside is to experience a wholesome sensation of reality. This is she who is friend to the stranger, help to the helpless, comfort to the wretched and to the frightened strength. This is she whose kind and skilful hand makes endurable the horrid agony and mitigates the obscene pang. This is she whose charity envelops the dying and the doomed.

Sunset and evening star,
And one clear call for me.
And may there be no moaning of the bar,
When I put out to sea.

This is she also whose hands lift up the infant cast forth wailing with travail upon earth, Alpha and Omega, the beginning and the ending.

Fond man, that meddlest rashly with high matters that thou dost not understand. In all that fantastic world of thine, jungles of military and industrial psychology, stony savannahs of facts and figures, barren commons where committees browse, there is not one thought of the nurse's care of her patient. What, pray, is nursing for? I know thine answer: "Reduction in the cost of sickness and value of work lost."



To Those Completing the Clinical Period

YOU have now been engaged for some considerable time in the multifarious duties of the Clinical Period.

If you have applied yourself diligently to your studies, you will, by now, have dozed through a large number of systematic lectures, given by men of the highest ability and competence obtainable at the nominal remuneration offered by the School, and will have eaten sandwiches at clinical lectures on a great diversity of subjects given by famous men, for no honorarium beyond the possibility of immortality in print in the *Gazette*.

What advantage have you taken of your opportunities ? Besides the satisfaction of knowing that you have been signed up for 74.9 per cent. of the lectures, or the even greater satisfaction of having personally signed yourself up, there is the secondary consideration of what educational benefit you have derived.

If you have been wise, before you left the lecture hall you have asked your neighbour to sketch out, in a few words, what subjects the lecturer covered. Or, alternately, you made a point of contacting a friend as he came out, in order that you might make a note of these topics (to read them up during your period of study, after dinner and before the nine o'clock news). If you did, by now you will probably have quite a pile of these handy references, which you are hoping to run through one day, when you have nothing better to do.

By now you will be in a position to decide whether you wish to continue your professional studies. To this end, probably the best plan is to purchase a text-book on either Medicine or Surgery, preferably one with profuse coloured and schematic illustrations. (Do not fall into the common error of imagining that a large book is necessarily a good one).

Should you by any chance be interested, you will no doubt buy or borrow *both* these books, together with a handy pocket volume on Pathology.

If you intend to specialise, in place of these, you will do well to have access to a work on the Famous Names in Medicine and may feel you require, also, a copy of the " Infant Life Preservation Act " of 1929.

You should inquire, from the appropriate house officers, as to whether rounds are still being conducted on any of the firms. Most of the clinicians and registrars are only too pleased to discuss patients on their round. Should you follow up this line you will, of course, want to give first preference to the Registrar under whose name you once found your own on the notice board in the Medical School. This may have some bearing on your eligibility when house appointments are being considered.

As regards examinations, I might mention that if your name is not among those on the list forwarded to you in your stamped addressed envelope, it should be taken as an indication from the Senate that they approve of your being allowed to undertake further study in the respective subjects. The student is expected to defray the expenses of this extended undergraduate course himself.

Always remember it was a physical impossibility to cover the course and, should you feel you may have done so, you should consult your physician immediately, as you are probably developing a severe affective psychosis.

K.J.R.

Poem

THE AUTONOMIC SYSTEM

He spoke in terms I did not know
Of structures that he did not show,
That passed from depth's I'd not explored
To places previously ignored.
He talked of nerves that did arise
From parts quite hidden from my eyes :
They traced a course I did not care
To parts I never knew were there—

Such words I trust one seldom hears
Within a lady student's ears.
And when the class had staggered out
Too dazed to speak (and too devout)
I lingered on the words I knew,
I counted up the fearful few,
And found, alas, they were the same
That I possessed when in I came.

Anon.

Christmas Quiz

For the soporific half hour after Christmas lunch, or any other idle moment over the holiday, we provide you with the following test. (Answers at the end)

I. *Which of the following are*

(i) Governors of the Hospital
a) Sir John Conybeare *b*) Lord Moran *c*) J. Arthur Rank
d) Prof. Munro Kerr *e*) Ian Hay *f*) The Radio Doctor.

(ii) Named after Guy's men
a) Bell's Palsy *b*) Bright's Disease *c*) Bryant's Triangle
d) Lane's Forceps *c*) The Circle of Willis *f*) Guy's Pill

(iii) Qualified Medical Practitioners
a) Somerset Maugham *b*) Francis Brett Young *c*) Dorothy Sayers
d) James Bridie *e*) A. J. Cronin *f*) H. V. Morton

II. *How many*

(i) Dental Extractions were performed last year at Guy's?
a) 7,140 *b*) 843 *c*) 19,621

(ii) Dental Chairs are there in the Hospital?
a) 35 *b*) 85 *c*) 105

(iii) Feet high is the Central Tower of Hunt's House (excluding the iron lantern)?
a) 200 *b*) 250 *c*) 275

(iv) Persons are likely to be found within the bounds of the Hospital at noon on a week-day in term?
a) 800 *b*) 2,300 *c*) 3,000

III. *Are the following statements true or false*?

(i) The average cost of each in-patient per week is higher in Nuffield House than in the General Wards?

(ii) The Statue of Thomas Guy in the front quadrangle was designed by Scheymaker.

(iii) St. Thomas's Hospital once stood in St. Thomas's Street, opposite Guy's.

(iv) Ship and Shovel are the names of two College Porters.

IV. *Who wrote the following*?

(i) "Here, where men sit and hear each other groan;
Where palsy shakes a few, sad, last grey hairs,
Where youth grows pale and spectre-thin and dies;"

(ii) "In the south suburbs, at the Elephant
Is best to lodge."

(iii) "The Pantheon, the Grotto Gardens, the Borough and such places where the Nobility chiefly resort."

V. (i) The average age of Guy's students qualifying as Medical Practitioners in October, 1947, was,
a) 27 *b*) 26 *c*) 23 *d*) 24

(ii) The average age of First and Second Year Medical Students entering Guy's in October, 1947, was,
a) 19 *b*) 23 *c*) 21 *d*) 25

(iii) How many of these (90 odd) new students were married on entry?
a) 3 *b*) 9 *c*) 57 *d*) 22

(iv) Hunt's House is named after
a) a Surgeon *b*) a Physician *c*) a silk merchant *d*) an American Soap King.

VI. (i) Which of the following Guy's men was awarded the greatest number of International Rugby Caps?
a) W. D. Doherty *b*) R. C. S. Dick *c*) E. Morgan.

(ii) The Coronation Scurry Stakes is or was,
a) An annual sweepstake held by the Residents.
b) A race at Ascot, the proceeds of which are given to the London Voluntary Hospitals.
c) A donkey race.

(iii) The first Inter-Hospitals Rugby Football Final was played in 1875. Who were our opponents and who won?
a) St. George's *b*) St. Mary's *c*) St. Thomas's.

VII. (i) Guy's was founded in,
a) 1584 *b*) 1653 *c*) 1725.
(ii) Thomas Guy was,
a) a vegetable merchant *b*) a bookseller *c*) a north country brewer.
(iii) The College at Guy's was opened in 1890, by
a) The Prince of Wales *b*) The Bishop of Rochester *c*) Mr. Gladstone.
(iv) In 1880 a Guy's Nurse was indicted at the Central Criminal Court for feloniously killing and slaying a patient. What did she do?
a) Threw a baby out a second-storey window
b) Gave a patient a cold bath
c) Administered an enema under high pressure.

VIII. *Who stated,*
(i) "For there is no person, let his station in life be what it may, whom, if I were disposed to dissect, I could not obtain."?
a) John Hunter *b*) Astley Cooper *c*) Prof. T. B. Johnston.
(ii) "Old people, on the whole, have fever complaints than young"?
a) Hippocrates *b*) T. B. Layton *c*) Sir William Osler.
(iii) "It is not possible, without drowning the baby, to keep it warm in a bath of water and to keep its head lower than its trunk at the same time"?
a) Archimedes *b*) Dr. H. St.H. Virtue *c*) Mr. G. F. Gibberd.
(iv) *and who recommended*
"In certain case, when the patient is remarkably timid, to deceive him by telling him that the operation has been put off until another day, and while in the act of making as it were, preparations for it, to perform the necessary incision"?
a) Mr. Hedley Atkins *b*) Galen *c*) Laennec.

Reviews

Health Services in England. By R. C. WOFINDEN. Bristol: John Wright & Sons, Ltd. London: Simpkin Marshall (1941), Ltd. Pp. 191. *Price* 10*s*.

IT is one of the tragedies of our time that the Health Service which is to come into being on July 5th of next year was not ready by the autumn of 1945, so that those who had been working in the various services of that time could have stepped straight into it bringing their experience of what was good and what was bad in the temporary Services of War into the permanent one of Peace. This was largely due to the utter ignorance of the vast majority of our profession that such a service was necessary and overdue. From this stupor they were rudely awoken by the great Beveridge Report. All those persons who had worked upon Insurance Committees throughout the land, and those who had given their services equally to the municipal and voluntary hospitals had known for 20 years that it must come. But the ignorance of the many made necessary all those discussions first between branches of the profession and then between its leaders and representatives of the Ministry of Health, which should have taken place years previously, and which lost two precious years between the end of the war and the new Health Service.

The majority of the profession will do so now, as will most of those who qualify from now on, while those who do not can no longer ignore it, nor continue to know nothing about it. It is to be feared that there are still many in a state of ignorance. They must have no excuse for this by July, 1948. Here then is a little book that sets it all down. It is written by a member of the administrative branch of our profession. It therefore states what it is thought to-day is needed and what the State is providing. It will be for the Clinical branch of medicine to decide how the work is to be done, the aim to be set, the code in which it is to be conducted, and the standard of responsibility under which to serve. How high these ideals will be must largely depend upon what is done in the first year. A great responsibility therefore rests upon the shoulders of all present members of our profession under the age of 45, and upon all those now coming into it. Let them give more than they can ever hope to receive.

T.B.L.

Sport

RUGBY FOOTBALL

GUY'S *v.* SWANSEA

at H.O.P. Lost 11—6.
6th December, 1947.

Swansea defeated the Hospital in a first-class game, having led since half-time. Their team, capably led by Glynn Davies the Welsh international full-back, gave a capital display and well deserved their victory.

Play began on a saturated pitch, which rapidly became mud and well suited the Swansea team, whose own ground is rarely dry, and the Hospital were soon on the defensive. Brunow, playing at full-back, relieved with a long kick to touch and Guy's went into the attack. Brunow kicked a penalty goal but Swansea replied with a similar goal five minutes later.

The game speeded up considerably after half-time with the handling on both sides standing up well to the difficult conditions. Ten minutes play had gone when Swansea landed a second penalty goal for an offence in front of our posts to give them a 6—3 lead. The Hospital rallied well and pressed home a number of attacks only to find the Swansea defence too safe.

Swansea scored a try which was converted, following an opportunist move round the blind side of the scrum—the Hospital replying a little later with an unconverted try by Billingham, who rounded off a beautiful movement in which both forwards and three-quarters played a part. The Hospital then went into the ascendency: Cottier and Gray came near to scoring but the Swansea defence held strong to leave them worthy winners.

GUY'S *v.* OLD CRANLEIGHANS

at Thames Ditton. Won 14—0.
13th December, 1947.

Guy's returned to winning ways at the expense of the Old Boys despite fielding a side weakened by examination and Hospital calls. The game was scrappy in the extreme and the score does not credit the Hospital with their true superiority. The forwards were never together in the scrum, and persistant wheeling (a result of loose packing) did not help in getting the ball out. The three-quarters were handicapped by this slow heeling and the wings who looked dangerous whenever they got the ball were never exploited to their full.

Guy's opened the scoring with a breakaway try by Hatton and went further ahead with a try by Billingham, who collected a smart cross-kick very cleanly and crossed the try line untouched. Both kicks at goal failed.

After the interval, Guy's were rarely out of their opponents half but seldom had the penetration which is so necessary to score. Gray crossed twice after excellent runs only to find that he had put one foot in touch, but at a third attempt rounded off an excellent movement to score a try converted by Billingham.

Lewis, making an extra man in the three-quarter line, scored just before the end to give Guy's a fourteen point victory.

THE DRAW FOR THE INTER-HOSPITAL RUGBY FOOTBALL CUP, 1947-1948

We congratulate J. H. Keeling who has been selected to play for England against The Rest in the final trial on December 20th.

BOXING

GUY'S *v.* TRINITY COLLEGE, DUBLIN

at the Seymour Hall. Won 5—3.
5th December, 1947.

The boxing club and co-opted organisers produced an excellent evening's sport for a well-filled hall. Guy's were lucky to come away the victors by so clear a margin as a number of fights might easily have gone the other way. The supporting bouts, if not supplying the same partisan excitement as the team match, supplied some excellent boxing, in particular did two small boys, Collins and Hack long past their bed-time, in gum shields and boxing boots, give a most polished display. It was fortunate that neither got lost in the hole Bruce Cole made with the back of his head there nearly a year ago. The programme was misleading, and the fight for a drink at the bar in the interval, one of the best of the evening.

Z. Woolfson (T.C.D.) beat D. Harris (Guy's) whom he knocked down coming out of a clinch, and although the latter fought pluckily on, the referee stopped the fight in the second round.

C. J. Bayley (Guy's) beat J. Pretorius. After the Trinity man had hit the canvas twice and got up bleeding profusely from the nose, this fight too was stopped.

E. B. McHugh (T.C.D.) beat W. Sheeran. Sheeran had the Irishman down twice early on, but was himself floored later.

E. Mears (T.C.D.) beat J. G. Lymberry, who despite going down in the first round, and getting up very groggy on his feet, most pluckily hung on with his left outstretched, until the fight was stopped. From there on Guy's won all the fights.

A. E. McLaughlan beat R. Ferguson, the fight being stopped when the latter, very mazed, faced the corner instead of the ring.

N. Porter beat A. P. S. Sheridan after he himself had looked like being thrashed. The crowd wanted a draw in this hard punching even match, which ended with both the boxers too tired to stand up, but the referee would not have it.

H. St. John beat G. Bell after yet another great punching match, in which both gave and received punches and blood most generously.

Finally that old rogue, R. D. Walsh, beat B. P. Maguire in what was a fairly closely calculated fighting withdrawal.

HOCKEY

GUY'S *v.* LONDON HOSPITAL

(1st Round Inter-Hospitals Cup)
Away. Won 6—0.
3rd December, 1947.

In the first half Guy's faced a sound London defence. Earl and Vans Agnew made many openings for the forwards, but individual play, at the expense of team-work produced but one goal. At half-time, Warren (London centre-half) moved up to the forward line. Guy's forwards, taking advantage of a weakened defence, pressed to score five goals. Hodson following up a shot from Blake

hit the ball first time from an almost impossible angle to score the outstanding goal of the game. Goals : Earl (4), Blake (1), Hodson (1).

Guy's missed Kelsey Fry, absent through injury. Vans Agnew moved up from the defence to play a neat, economic game. Carter, a welcome stranger, played well with Danford in a defence, perhaps lacking in clean clearing technique, but by their excellent tactics equal to the London forwards at every stage of the game.

Team : F. H. Walker, G. H. Danford, H. Carter, C. H. Opie, E. A. Murray (Captain), R. A. Keable-Elliott, D. V. Duckworth, D. Blake, S. S. R. Earl, W. Vans Agnew, R. F. Hodson.

GUY'S *v.* INLAND REVENUE

Away. Won 3—1.

6th December, 1947.

On a sticky pitch Guy's were robbed of their main advantage—speed. The disadvantage was increased by the Revenue team having a few solid veterans who stopped balls regardless of velocities and angles. Play was fast considering the state of the pitch. Blake (Guy's) scoring the only goal of the first half. After half-time Revenue pressed hard and deserved their equalising goal, after which Guy's played better. Opie, playing as usual a sound game, helped Duckworth to outflank the defence on several occasions. Blake, taking a through pass from Keable-Elliott, dribbled the ball into the goal to put Guy's in the lead again, which was consolidated by Blake from a rising ball, a shot to be admired in cricket and marvelled at in hockey.

Team : F. H. Walker, G. H. Danford, A. H. Rowe, C. H. Opie, E. A. Murray (Captain), R. A. Keable-Elliott, D. V. Duckworth, R. F. Hodson, D. Blake, C. F. M. Robinson, D. Thomas.

ASSOCIATION FOOTBALL

GUY'S *v.* LONDON HOSPITAL

Won 3—2.

6th December, 1947.

Goals by Skaith (1), Leckie (2).

Team : A. H. Whitaker, D. G. Matthews, P. J. Holloway, D. Harris, H. R. C. Riches (Captain), P. A. Swift, R. Skaith, E. Sturdy, J. C. Leckie, N. I. Lewis, P. W. Head.

GUY'S *v.* ROYAL MARINES, CHATHAM

at Chatham. Lost 2—4.

10th December, 1947.

Playing against probably the best side they met this season, Guy's were given their annual football lesson. However, remembering that R.M. more than hold their own against such professional sides as Gillingham, Dartford and Margate in the Kent League, the team in no way disgraced itself.

Guy's played as if overawed by their opponents reputation at first, and were fortunate not to be more than one goal down after twenty minutes. Two quick goals—one a fine effort by Sturdy from 15 yards range, and the other an opportunist goal by Swift restored the team's confidence, but the R.M.'s clever forward line scored twice to make it 3—2 at half-time.

R.M. had most of the second half play, but the Hospital defence was now playing soundly whilst the forwards were by no means out of the picture. Towards the end they attacked strongly, and in an inspired spell only excellent goalkeeping prevented Lewis (twice) and Skaith from scoring. R.M's weathered the storm and put the result beyond doubt with a beautiful goal, scored in the last thirty seconds.

It was a very clean game, with Riches a capital "stopper" centre half, Lewis a constructive inside left, and Swift, playing his first game this season, in his old position of left wing.

Team : A. H. Whitaker, S. T. G. Jones, D. G. Matthews, E. M. Newton, H. R. C. Riches (Captain) D. E. Harris, R. Skaith, D. E. Sturdy, J. C. Leckie, N. S. Lewis, P. A. Swift.

GUY'S *v.* HENDON

at H.O.P. Lost 3—4.

13th December, 1947.

As against R.M. (Chatham), Guy's started off on a very soft pedal, and hardly entered into the picture for the first half hour, during which time Hendon (a reserve side of the Athenium League Club) played attractive forceful football, and scored twice. Guy's improved just before the interval, but Hendon had little difficulty in retaining their lead.

Shortly after half-time, Lewis reduced the arrears with a good left-foot shot, but Hendon went even further ahead with two more goals, both of which bore that slight element of luck which wins close games. 4–1 down Guy's began fighting back, and Lewis after a goalmouth melée forced the ball home from short range. Immediately from the kick-off after this goal, Lewis intercepted a pass and working solo through the whole Hendon defence completed his hat-trick with a right-footed cross shot. Thereafter it was all Guy's, who but for some astounding misses could have equalised, and even won.

It was another extremely enjoyable game with Hendon just worthy winners, because of their first-half display.

Lewis was Guy's outstanding player, whilst Holloway gave another sound polished performance at left back.

Team : A. H. Whitaker, S. F. Westgate, P. H. Holloway, D. G. Matthews, H. R. C. Riches (Captain), D. E. Harris, R. Skaith, E. M. Newton, J. C. Leckie, N. I. Lewis, P. Head.

GUY'S HOSPITAL SQUASH CLUB

This season the Squash Club entered "The Cumberland Cup," a league competition embodying a number of clubs situated in the London Area.

The first half of this competition is now complete with Guy's having won two of the five matches played, as follows :—

Oct. 28th	against	Priory S.C. ..	Lost 1—4.
Nov. 4th	,,	Hornsey S.C. ..	Won 4—1.
,, 11th	,,	Hampstead C.C.	Lost 2—3.
,, 18th	,,	Northwick C.C.	Won 3—2.
,, 26th	,,	Coolhurst C.C.. .	Lost 0—5.

The Hospitals Cup has also been resumed after a lapse during the war years. Two Rounds have now been played in which Guy's beat University College Hospital 3—2, and St. Mary's Hospital 4—1, thus entering the semi-final which will be played before the end of January.

The following players have represented the Hospital :—

C. J. G. Menzies (Capt.) G. M. Evans
L. Jacobs D. R. Saunders
P. Maxted A. W. R. Williamson
W. Maile D. R. Pugh
P. S. Carton Kelly J. Goodfellow
H. E. H. Gillett

RIFLE CLUB

GUY'S *v.* HIGHGATE SCHOOL

Lost 571—562.

GUY'S *v.* ST. MARY'S HOSPITAL

Won 576—568.

GUY'S *v.* KING'S COLLEGE, LONDON

Won 585—581.

HOSPITAL BLUES.

At a recent meeting of the Blues Committee, the following awards were made :—

Cricket Club.

Full Blues : R. G. Nicholson, H. M. C. O'Driscoll, G. P. Billingham, P. S. Holmes.
Half Blues : P. S. Russell, C. H. Talbot, M. C. Gilbert.

Hockey Club.

Half Blues : R. A. Keable-Elliott.

Tennis Club.

Full Blues : I. Kelsey Fry, F. M. Hulme.
Half Blues : R. Merrill, E. Searle.

Squash Club.

Half Blue : P. Maxted.

Golf Society.

Half Blues : J. M. D. Grant, D. J. Cottier, J. K. Anderson, N. E. Price, W. Vans Agnew.

Athletic Club.

Full Blues : D. J. Joubier, E. MacKensie, B. Hartley, B. G. C. Christie.
Half Blues : D. Le Clus, C. R. E. Baker, J. Southgate, F. Retief, P. T. C. Rowan.

Swimming Club.

Full Blues : B. M. Gray, P. Kendal.
Half Blues : M. Ashby, W. J. Wolfsohn, M. Smallcombe.

ERIC W. GRAHAM,
Hon. Sec., Blues Committee.

The London University Purple has been awarded to K. M. Hume for the tennis season of 1947.

Hospital Information, etc.

NOTICES

PRELIMINARY NOTICE.
GUY'S HOSPITAL DENTAL SOCIETY.

The Clinical meeting will be held next year on March 6th, 1948, in the Dental Department. A reception has been arranged at the Park Lane Hotel, Piccadilly, W.1, for the evening, and we are very hopeful of obtaining a permit from the Ministry of Food to arrange for a dinner. Failing this, a full buffet will be served.

ASTLEY COOPER STUDENTSHIP.
GUY'S HOSPITAL.

This Studentship, tenable at Guy's Hospital Medical School, will become vacant in January, 1948.

The student, who is called the "Astley Cooper Assistant to the Curator of the Gordon Huseum," will be elected for a period of three years.

Particulars regarding the Studentship can be obtained from the SECRETARY to the Astley Cooper Trustees, Medical School Office, Guy's Hospital, S.E.1, to whom applications for the post should be addressed on or before 17th January, 1948.

GUY'S HOSPITAL.—ASSISTANT OBSTETRIC SURGEON.

Applications are invited from Service candidates and others for the appointment of Assistant Obstetric Surgeon to Guy's Hospital. Copies of Standing Orders for the appointment can be obtained from the Superintendent, to whom letters of application (20 copies), together with the names of three referees, should be submitted not later than 31st January, 1948, and from whom any further information desired can be obtained.

GUY'S HOSPITAL.—ASSISTANT PHYSICIAN.

Applications are invited from Service candidates and others for the appointment of Assistant Physician to Guy's Hospital. Copies of Standing Orders for the appointment can be obtained from the Superintendent, to whom letters of application (20 copies), together with the names of three referees, should be submitted not later than 31st January, 1948, and from whom any further information desired can be obtained.

GUY'S HOSPITAL DENTAL SCHOOL.

The undermentioned Postgraduate courses, each of two weeks' duration, will be held in 1948 :—

Dental Prosthetics—commencing 9th February.
Orthodontics and Children's Dentistry—commencing 23rd February.
Advanced Operative Technique—commencing 8th March.

The fee is 20 guineas for each course.

A course in Dental Radiology will also be held; one session will be devoted to Radiography and the fee will be 4 guineas. The dates are as follows: 24th March at 2.30 p.m.; 3rd, 10th and 17th April at 10.30 a.m.

PASS LIST

UNIVERSITY OF LONDON.
DIPLOMA IN TEACHING.
July, 1947.

Miss G. C. M. Gill, S.R.N.
Miss A. Lewin, S.R.N.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.
F.R.C.S.
FINAL EXAMINATION.
November, 1947.

W. E. S. Bain — J. Fry
J. F. R. Bentley — D. N. Fuller
H. P. Guerrier

SOCIETY OF APOTHECARIES OF LONDON.
FINAL EXAMINATION.
November, 1947.

Pathology, Bacteriology and Forensic Medicine.
A. C. Bojé — M. P. Cardew
Midwifery.
D. M. Strange.

ROYAL COLLEGE OF OBSTETRICIANS AND GYNÆCOLOGISTS.
Diploma in Obstetrics.
November, 1947.

G. J. Amiel — V. Drosso
S. N. Cole — A. Eckford
H. H. Crabb

UNIVERSITY OF CAMBRDGE.

The degree of Doctor of Medicine has been conferred on Edward Clayton-Jones.

SOCIETY OF APOTHECARIES OF LONDON.

B. H. Bickmore has now completed the examination.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.
L.D.S.

FINAL EXAMINATION.
November, 1947.

Part I.—Surgery.

P. J. Attenborough	W. G. Selley
A. A. Bailey	R. E. Simmons
L. Becker	P. H. Smith
E. B. Busfield	K. S. Sunaway
D. J. W. Foster	R. D. F. Thiel
T. R. Foster	D. F. Waller
J. B. Harris	J. R. Waller
S. Korodemas	G. P. J. Williams
R. A. J. Mayhew	R. S. Wilson
G. G. Phillips	W. J. Wolfsohn

Part II.—Dental Surgery.

H. V. Cockburn	R. A. J. Mayhew
R. E. Feaver	S. H. B. Taylor
A. W. Hilliam	W. J. Tulley
P. S. Holmes	S. F. A. Westgate
S. P. Johns	E. J. Williams
G. E. King-Turner	

UNIVERSITY OF LONDON.
GENERAL SECOND EXAMINATION FOR MEDICAL DEGREES.
September, 1947.

B. I. Copeland	J. A. Rycroft
D. Lennie	H. Windschauer

APPOINTMENT

Brian D. Johnson, M.R.C.S., L.R.C.P., D.A., has been appointed Senior full-time Anæsthetist to the City General Hospital, Leicester.

PAPERS BY GUY'S MEN

Blackburn, Guy, and Another. Synchronous combined Total gastrectomy. *Brit. Med. J.*, 1947, ii, 817.

Bradley, W. H. Public Health, Epidemiology and preventive medicine. *Med. Annual*, 1947.

Blacker, C. P. Stages in population growths. *Eugenics Review*, 1947, cx, 88.

Clarence, P. S. The avoidance of a casting defect. *Brit. Dent. J.*, 1947, vc, 240.

Douthwaite, A. H. Chronic rheumatic disorders. *Med. Annual*, 1947.

Forman, L. Acne Conglobata. *Proc. Roy. Soc. Med.*, 1946–7, xl, 699.

Hankey, G. T. Three cysts of the same mandible not of dental origin. ? Solitary cysts or osteitis fibrosa. *Ibid.*, 723.

Middleton, R. Symmetrical tuberculated supernumerary teeth posterior to the first upper incisors. *Brit. Dent. J.*, 1947, vc, 216.

Reid, D. J. Misplaced maxillary canine and first premolar. *Brit. Dent. J.*, 1947, vc, 217.

Simpson, Keith. Pathology of sudden death. *Lancet*, 1947, ii, 745.

Waterfield, R. L., and Others. Streakiness of blood films, relation to sedimentation—rate and plasma—fibrinogen. *Lancet*, 1947, ii, 831.

CHANGES OF ADDRESS

D. N. Leeming, M.R.C.P., Cilgwyn, Old Colwyn, Denbighshire.

T. C. L. Parry, M.A., M.B., B.Ch., 41, Portland Street, Fareham, Hampshire.

C. Beales, L.D.S., R.C.S., 6, The Broadway, Woodford Green, Essex. (Tel. Buckhurst 0262.)

J. W. A. Crabtree, Abbotsleigh, Rolle Road, Exmouth. (Tel. 2110.)

BIRTHS

HOUSDEN.—On December 3rd, 1947, at the Somerville Nursing Home, Hereford, to Pamela (née Capon), wife of Charles Housden, L.D.S., R.C.S.,—a daughter.

JENMAN.—On December 4th, 1947, at Livingstone Hospital, Dartford, to Dorothy, wife of James L. Jenman, M.R.C.S., L.R.C.P.—a daughter (Susan Anne).

LLOYD.—On December 1st, 1947, at Nuffield House, to Dilys (née Hughes), wife of D. Owen Lloyd, M.B., B.S., D.P.M.—a daughter (Catherine Gwendolen Owen).

MANSIE.—On December 6th, 1947, at 9, Carlton Drive, S.W.15, to Enid (née Kirkpatrick), wife of James Mansie—a son.

TIBBS.—On December 14th, 1947, to Paddy (née O'Meara), wife of D. J. Tibbs, M.C., M.B., B.S.—a son (a brother for Teresa), Nigel John.

MARRIAGES

WILLAN—KINGHAN.—On November 1st 1947, at St. George's, Hanover Square, by the Bishop of Dover, Lieut.-Cmdr. D. P. Willan, D.S.C., R.N., to Patricia M. Kinghan, S.R.N.

CHRISTMAS QUIZ ANSWERS

(Full marks 100)

I.

(i) *a*) Yes, *b*) No, *c*) Yes, *d*) No, *e*) Yes, *f*) No. [6].
(ii) *a*) No, *b*) Yes, *c*) Yes, *d*) Yes, *e*) No, *f*) No. Guy's Pill is named after William Augustus Guy, 1819–1900. [6].
(iii) *a*) Yes, *b*) Yes, *c*) No, *d*) Yes, *e*) Yes, *f*) No. [6].

II.

(i) *a*) [2].
(ii) *c*) [2].
(iii) *a*) [2].
(iv) *c*) [2].

III.

(i) False. In 1946 the figures were £14–0–0 and £14–18–8. [3].
(ii) True. Made in brass; it cost 500 guineas. [3]
(iii) True. St. Thomas' moved in the 1860's, after over 600 years on this site. [3].
(iv) False. "The Ship and Shovel," a famous Guy's pub, was destroyed early in the war. [3].

IV.

(i) John Keats, one time Guy's student, in "Ode to a Nightingale." [5].
(ii) William Shakespeare in "Twelfth Night." [5].
(iii) Oliver Goldsmith, who at one period of his life, set up as "a physician in a humble way" on Bankside, in "She Stoops to Conquer." [5].

V.

(i) *c*) [3].
(ii) *b*) Those qualifying were slightly older than those entering, 23.6 as against 23.2. [3].
(iii) *b*) [3].
(iv) *c*) William Hunt, the "Second Founder of Guy's," left £180,000 to the Hospital in 1829. [3].

VI.

(i) *c*) "Teddie" Morgan, who played for Wales 16 times. [3].
(ii) *c*) A traditional event at the Annual Guy's Athletic Sports. [3].
(iii) *a*) [3]. And Guy's won! [2].

VII.

(i) *c*) [3].
(ii) *b*) [3].
(iii) *c*) [3].
(iv) *b*) Unknown to the nurse, the patient was suffering from tuberculous meningitis. [3].

VIII.

(i) *b*) In evidence before a Select Committee of the House of Commons in 1830, which was considering how to end the practice of body snatching. [3].
(ii) *a*) "Aphorisms." [3].
(iii) *c*) "A short Textbook of Midwifery," 4th Edn., page 516. [3].
(iv) *b*) [3].

EDS. {H.A.R. R.A.K-E.